MEDICUS™
INSURANCE COMPANY

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company will offer the insured premium payment options, outlined on Page 28.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on Page 25.

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination.

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Scheduled Rating is not to be used in conjunction with Loss Rating.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated under B1 on page 7.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any applicable modifications. However, for groups of 10 or more physicians, the Company may base the maximum premium on the sum of the shareholders' rated classifications.

3. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met. These limits of coverage are shared, unless otherwise specified by endorsement.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company,

uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III.A.1 on Page 5:

20% - Separate Corporate Limits

10% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $1250.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Schedule Rating is not to be used in conjunction with Loss Rating.

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non-physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown on Page 21, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found on Pages 14-19 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

2. A Part Time Practitioner may include any practitioner in classes 1 through 3 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated on Page 26.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on Page 26. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to L.5 on page 26 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on Page 26.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented on Page 26.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated on Page 27, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Self-Insured Retention Credits

1. Self-Insured Retentions

a. SIR'S shall be offered to qualified insureds, provided the account generates $250,000 or more of manual premium. The eligibility threshold shall be 5 physicians in a medical group. The actual experience of the account will be analyzed and the appropriate credit determined. The items considered in the

determination of the applicable credit are: the historical paid frequency; historical paid severity; historical incurred severity; the historical allocated loss adjustment expenses as a percent of indemnity; the processing; acquisition and other expenses associated with the account; the variability of results; the credibility of the experience; the selected deductible annual aggregate; and the loss elimination ratio from the lognormal distribution. The table of SIR's and credits is below:

Per Claim Self Insured Retention	Credit As a % of 1M/3M Premium
$100,000	12%
200,000	20%
250,000	22%
500,000	35%
1,000,000	43%

b. SIR's shall be funded at the discretion of the Company, including vehicles such as irrevocable Letters of Credit, Cash or equivalent, or escrow accounts.

c. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

d. SIR's can only be revised at policy renewal.

e. The SIR credits shall apply to the primary limit premium, net of other applicable credits.

i. The credits are expressed as a function of the Per Claim limit of liability or per insured and aggregate SIR limit.

ii. The insured may be eligible for an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

C. Experience Rating

Experience Rating is under review. It is currently not available.

D. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided on Page 26 under M.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine
Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases

Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS

Otorhinolaryngology-MRP, NMajS
Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery
Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP, Nmaj

Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS
Family Practice-not primarily
MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery

Otorhinolaryngology; Head/Neck
Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than
Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological
Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial
Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Class 1 – Physician and Surgeon Rate

Psychologist

Class 6 – Physician and Surgeon Rate

Certified Registered Nurse Anesthetist

Class 13 – Physician and Surgeon Rate

Certified Nurse Midwife – No complicated OB or surgery

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	85%
Fourth Year (Mature):	100%

D. Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289

4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009

10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Otorhinolaryngology; No Elective Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
12	Emergency Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
15	Orthopaedic Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

E. Mature Rates for non Physician Health Care Providers

Class X equals 10% of the Class 1 Physician/Surgeon rate.

Class Y equals 15% of the Class 1 Physician/Surgeon rate.

Class Z equals 25% of the Class 1 Physician/Surgeon rate.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 4 rate.

F. Decreased Limit Factors:

Limit	All Classes
1M/3M	1.000
500/1.0	.7199

G. Extended Reporting Period Coverage Factors:

(1) The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

(2) The Reporting Period is unlimited.

H. Shared Limits Modification:

Not available.

I. Policy Writing Minimum Premium:

Physicians & Surgeons - $1250.

J. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

K. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

L. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – 1st Year Resident 50%; Resident 40%; Fellow 30%.
3. Locum Tenens – no premium, subject to prior underwriting approval
4. New Physicians & Surgeons – 30% for the first two years of practice
5. Physician Teaching Specialists – Non-surgical 50%; Surgical 40%.
6. Physicians Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval

M. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

(i) If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date.

(ii) If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

(iii) If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

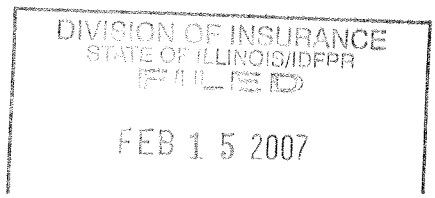
(iv) If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

N. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 25%



O. Self-Insured Retention Credits for groups, subject to Underwriting

See V.B on Page 11.

P. Experience Rating

Not Available.

Q. Slot Rating for groups, subject to Underwriting

See VI.A on Page 13.

R. Mandatory Quarterly Payment Option.

For medical liability insureds whose annual premiums total $500 or more, the plan must allow the option of quarterly payments.

(v) An initial payment of no more than 40% of the estimated total premium due at policy inception;

(vi) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

(vii) No interest charges;

(viii) Installment charges or fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and

(ix) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Non-Mandatory Quarterly Payment Option.

(x) For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans.

(xi) For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.

(xii) If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.

Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

ZACK STAMP, LTD.
ATTORNEYS AT LAW

601 West Monroe Street
Springfield, Illinois 62704

Telephone 217-525-0700
Fax 217-525-0780

Zack Stamp – Ext. 106
Kirk H. Petersen – Ext. 114
Kevin J. McFadden – Ext. 115
*Steve W. Kinion – Ext. 108
Rudolph M. Braud, Jr. – Ext. 118

OF COUNSEL:
Bonnie J. Williams – Ext. 201

February 15, 2007

Ms. Gayle Neuman
Division of Insurance
Illinois Department of Financial and Professional Regulation
320 W. Washington Street
Springfield, IL 62767-0001

Re: Medicus Insurance Company FEIN# 20-5623491
Submission of Rates, Rules, and Forms - Medical Malpractice Coverage
RATE/RULE FILING # 2007-R
FORM FILING # 2007-F

Dear Ms. Neuman:

The purpose of this letter is to submit the medical malpractice filing for Medicus Insurance Company. Enclosed you will find the following:

a. actuarial opinion by Richard J. Roth, Jr. dated January 17, 2007;
b. Illinois rates;
c. manual pages;
d. physicians & surgeons liability insurance policy;
e. policy endorsements; and,
f. application for physician/surgeon liability insurance.

Since Illinois is a file and use state my client immediately intends to begin using the contents of this filing. Thank you for your consideration and if you have any questions or comments, please call 525-0700 Ext. 108 or via email at *skinion@601w.com*

Sincerely,

Steve W. Kinion

1-D
NEM
KM
Jeh

*Also Admitted in Oklahoma

Neuman, Gayle

From: Paula Battistelli [pbattistelli@medicusins.com]
Sent: Monday, August 04, 2008 4:05 PM
To: Neuman, Gayle
Subject: Effective Date for Filing #2007-R

Dear Ms. Neuman,
In regards to an effective date for Filing #2007-R, Bruce and I believe that the effective date requested was February 15, 2007. If you have any questions, please contact me. Thank you.

Paula Battistelli
Regulatory Compliance Coordinator
Medicus Insurance Company
Direct: (512) 879-5128
Fax: (877) 686-0558
Email: pbattistelli@medicusins.com

Neuman, Gayle

From: Neuman, Gayle
Sent: Thursday, July 31, 2008 1:37 PM
To: 'Bruce Arnold'
Subject: RE: Medicus Rate Filing

Mr. Arnold,

We are still awaiting receipt of your response. The filing was submitted on February 15, 2007. Notes in the file indicate you had not issued any policies as of 4/17/07, and the second Medicus filing was submitted on 9/13/07 to be effective 10/1/07.

Your prompt attention is appreciated.

Gayle Neuman
Division of Insurance

-----Original Message-----
From: Bruce Arnold [mailto:barnold@medicusins.com]
Sent: Monday, July 21, 2008 2:05 PM
To: Neuman, Gayle
Subject: Re: Medicus Rate Filing

Ms. Neuman:
I'll get back to you shortly on this.
Thanks,
Bruce Arnold

On Jul 21, 2008, at 10:34 AM, Neuman, Gayle wrote:

> Mr. Arnold,
>
> We are holding up the closure of this filing as we are awaiting your
> response about the effective date. Your prompt attention is
> appreciated.
>
> Gayle Neuman
> Division of Insurance
>
> -----Original Message-----
> From: Neuman, Gayle
> Sent: Friday, July 11, 2008 7:52 AM
> To: 'Bruce Arnold'
> Subject: RE: Medicus Rate Filing
>
> Mr. Arnold,
>
> Filing #2007-R was submitted on February 15, 2007. The Director of
> Insurance has signed off on this filing was of July 7, 2008. I am
> contacting you to determine what effective date was used. Many
> insurers
> will ask for an effective date, but they end up waiting for the date
> we
> "file" the submission before they use it although that is not
> necessary.
> I did recall in a conversation that Medicus was holding up issuing
> policies at one point. So, please indicate the effective date to be
> used. Thank you for your assistance.

>
> Gayle Neuman
> Division of Insurance
>
> Original Message-----
> From: Bruce Arnold [mailto:barnold@medicusins.com]
> Sent: Thursday, July 10, 2008 4:58 PM
> To: Neuman, Gayle
> Subject: Medicus Rate Filing
>
> Hi Gayle,
>
> Steve Kinion said you had a question about our filing.
>
> I'll give you a phone call tomorrow morning.
>
> Thanks,
>
>
>
> Bruce Arnold
> Assistant Vice President
> Medicus Insurance Company
> 8500 Shoal Creek Blvd
> Building 3, Suite 200
> Austin, TX 78757
> 512-879-5103 office
> 512-590-2480 cell
>
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Bruce Arnold
Assistant Vice President
Medicus Insurance Company
8500 Shoal Creek Blvd
Building 3, Suite 200
Austin, TX 78757
512-879-5103 office
512-590-2480 cell

Neuman, Gayle

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Sent: Monday, July 21, 2008 2:05 PM
To: Neuman, Gayle
Subject: Re: Medicus Rate Filing

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Bruce Arnold
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Austin, TX 78757
512-879-5103 office
512-590-2480 cell

Rate Application

STATE OF ILLINOIS
Medicus Insurance Company

Physician Medical Malpractice

INTRODUCTION

This is a new company and a new program in Illinois. Medicus has no prior insurance history. All of the numbers are projections, based the financial experience of existing Medical Malpractice insurers.

The numbers given herein are consistent with Five-Year Financial Pro Forma information given to the Illinois Insurance Department.

1. After-Tax Target Rate of Return on Surplus	12 %
2. Premium-to-Surplus Ratio	100 %
3. Pre-Tax Average Return on Assets	5.4 %
4. Pre-Tax Realized Capital Gains/Losses (% of Assets)	1.5 %
5. Pre-Tax Unrealized Capital Gains/Losses (% of Assets)	1.5 %
6. Effective Tax Rate on Investment Income	35 %

Comments:

(1) It is normal in Medical Malpractice to have a premium to surplus ratio only 1:1, which is what is assumed.
(2) Most of the investment will be in bonds for the loss, expense, and unearned premium reserves. The surplus will be used mainly to fund receivables, which have no investment income.
(3) Expense ratios are common to the market.

Calculation of the Rate of Return on Surplus:

1. Permissible Loss and LAE Ratio	59.50%
2. Projected Expense Ratio	
a. Commission	12.0%
b. Other Acquisition	5.00%
c. General Expense	9.50%
d. Taxes, Licenses, & Fees	2.00%
e. Total	28.50%
3. Projected Investment Income (On Reserves) Ratio	5.40%
4. Projected Ancillary (Other) Income Ratio	0.00%
5. Projected Operating Return Before FIT 1-(1)-(2e)+(3)+(4)	17.40%
6. Federal Income Tax Rate	35%
7. Projected Federal Income Tax Ratio (5)x(6)	6.09%
8. Projected Operating Return After FIT (5)-(7)	11.31%
9. Premium to Statutory Surplus Ratio	1.00
10. Operating Return after FIT on Statutory Surplus (8)x(9)	11.31%
11. Projected Investment Income on Statutory Surplus	1.00%
12. Projected Federal Income Tax Ratio (6)x(11)	0.35%
13. Projected Invest. Income on Statutory Surplus after FIT (11)-(12)	0.65%
14. Total Return after FIT on Statutory Surplus (10)+(13)	12.0%

Group Affiliation: ISMIE Mutual Group

ISMIE MUTUAL INSURANCE COMPANY

20 North Michigan Avenue, Chicago, Illinois, United States 60602-4811
Web: www.ismie.com

Tel: 312-782-2749
Fax: 312-782-2023
AMB#: 03757
NAIC#: 32921
FEIN#: 36-2883612

RATING RATIONALE

The following text is derived from the report of ISMIE Mutual Group.

Rating Rationale: The rating reflects ISMIE's record operating profitability in 2005, lessened (albeit adverse) loss reserve development and its use of high quality reinsurers. These factors, however, are offset by ISMIE's marginally supportive risk-adjusted capitalization, significant reinsurance dependence and the inherent challenges associated with being a single state, monoline medical malpractice insurer, particularly as it relates to price competition, legislative (tort) reform, loss cost trends and regulatory challenges. This rating also takes into consideration the potential benefits to be gained from Illinois comprehensive medical litigation reform (SB475) offset by the dampening effects of current and future regulatory constraints brought on by the Illinois Insurance Department. Due to its marginal risk-adjusted capitalization, the rating outlook is likely to remain until this measure is strengthened to a level that more adequately supports its current rating. In the event ISMIE's BCAR falls below Best's minimum required, its rating is likely to be lowered. Continued operating profitability and further stabilization in loss reserve development are two key components.

These rating factors are supported by rate increases and re-underwriting initiatives taken by ISMIE in recent years, the recent introduction of tort reform (SB475), improved claim frequency, offset by a BCAR ratio that marginally meets Best's minimum required, historically adverse loss reserve development, ceded reinsurance leverage in excess of 200% (of surplus) and the potential regulatory constraints as it pertains to the Order issued by the Illinois Department of Insurance in March of 2006. ISMIE ranks as the leading medical malpractice insurer in the state of Illinois. ISMIE continues to benefit from its high policyholder retention, aggressive claims management and emphasis on risk management. In response to an availability crisis in the state of Illinois, a moratorium on new business was instituted in 2003 and remains in place through year end 2006.

Best's Rating: B+ g **Outlook: Negative**

	Profitability			Leverage			Liquidity	
Period Ending	Comb. Ratio	Inv. Yield (%)	Pretax ROR (%)	NA Inv Lev	NPW to PHS	Net Lev	Overall Liq (%)	Oper. Cash-flow (%)
2001	124.5	5.7	5.6	13.6	0.7	4.0	130.8	107.4
2002	155.8	5.1	-34.8	15.1	1.3	6.6	118.7	121.7
2003	118.6	4.2	-3.6	16.1	1.4	6.5	119.5	142.5
2004	114.3	3.9	3.5	15.8	1.1	6.1	119.8	115.0
2005	106.1	4.1	11.9	11.0	1.0	5.8	121.1	135.0
5-Yr Avg	122.6	4.5	-3.0	...	...	...	...	...
09/2005	109.1	XX	6.2	XX	1.0	6.4	118.7	131.9
09/2006	93.2	XX	25.7	XX	0.8	5.2	122.9	101.7

(*) Data reflected within all tables of this report has been compiled from the company-filed statutory statement. Within several financial tables of this report, this company is compared against the Medical Malpractice Composite.

KEY FINANCIAL INDICATORS

	Statutory Data ($000)		
Period Ending	Direct Premiums Written	Net Premiums Written	Pretax Operating Income
2001	207,961	175,461	8,731
2002	261,040	217,477	-70,360
2003	360,983	276,814	-9,290
2004	425,079	223,813	8,614
2005	405,279	247,471	28,896
09/2005	372,213	231,530	11,544
09/2006	350,789	196,778	42,998

	Statutory Data ($000)		
Period Ending	Net Income	Total Admitted Assets	Policy-holders' Surplus
2001	4,958	1,026,482	241,406
2002	-61,702	1,085,347	170,517
2003	19,834	1,236,885	201,669
2004	11,714	1,286,152	212,451
2005	23,580	1,357,282	235,899
09/2005	10,538	1,416,164	222,949
09/2006	27,681	1,427,768	265,947

FINANCIAL PERFORMANCE

The following text is derived from the report of ISMIE Mutual Group.

Being a leading writer of medical malpractice insurance in Illinois, underwriting and operating results continue to be largely influenced by changes in the state's medical malpractice insurance environment, particularly as it relates to price competition, legislative (tort) reform, loss cost trends and regulatory challenges.

In 2002, ISMIE strengthened prior year loss reserves by approximately $52.3 million, and produced a net underwriting loss of more than $115 million which resulted in a $61.6 million net after tax operating loss -- its worst year in ISMIE's history. Although improving since the watershed year of 2002, operating results have varied greatly and leave little to be desired when highlighting ISMIE's five-year average return on revenue (ROR) of -3.0%. Despite posting improved earnings in each of the last three years, these results continue to be dampened by prior year adverse loss reserve development as it relates to business written in 2002 and prior. These unfavorable results were driven by greater than anticipated claims severity and frequency, new business growth and management's effort to build a level of conservatism within its reserve base. Since the significant charge in 2002, loss reserves were once again strengthened by $10.2 million in 2003, another $34.4 million in 2004 and $3.9 million in 2005.

In addition to continued reserve strengthening over the years, management has implemented strict underwriting actions and placed a moratorium on new business (in 2002) in an effort to restore operating profitability. As a result of these initiatives, accident year results have improved significantly. At the same time, operating earnings and returns have also improved. In fact, in 2005, reported earnings for the year proved to be the largest in company history.

Going forward, however, A.M. Best is concerned with ISMIE's earnings prospects given the operational constraints related of the Order (refer to Recent Development section), the likelihood of increased competitive pressures from existing insurers as well as new entrants, such as captives and risk retention groups. Although loss reserves appear to be adequate, the potential for adverse reserve development still exists. In 2005, the pre-tax earnings impact related to adverse loss reserve development equated to $3.9 million.

UNDERWRITING EXPERIENCE

Year	Net Undrw Income ($000)	Loss Ratios: Pure Loss	Loss Ratios: LAE	Loss Ratios: Loss & LAE	Expense Ratios: Net Comm	Expense Ratios: Other Exp.	Expense Ratios: Total Exp.	Div. Pol.	Comb Ratio
2001	-41,152	72.4	37.0	109.4	6.0	9.1	15.1	...	124.5
2002	-115,509	100.7	37.9	138.6	7.2	10.0	17.2	...	155.8
2003	-50,450	73.2	31.6	104.8	5.2	8.5	13.7	...	118.6
2004	-32,134	60.8	39.5	100.3	3.3	10.7	14.0	...	114.3
2005	-15,520	49.7	44.2	93.9	3.0	9.2	12.2	...	106.1
5-Yr Avg	...	70.2	38.0	108.2	4.9	9.5	14.3	0.0	122.6
09/2005	-21,404	59.6	39.5	99.0	XX	XX	10.0	...	109.1
09/2006	7,800	43.3	38.1	81.3	XX	XX	11.9	...	93.2

PROFITABILITY ANALYSIS

	Company				Industry Composite			
Period Ending	Pretax ROR (%)	Return on PHS(%)	Comb. Ratio	Oper. Ratio	Pretax ROR (%)	Return on PHS(%)	Comb. Ratio	Oper. Ratio
2001	5.6	1.6	124.5	92.6	-10.1	-6.2	133.0	107.4
2002	-34.8	-31.7	155.8	133.5	-16.5	-15.1	134.3	115.2
2003	-3.6	15.5	118.6	102.6	-12.1	-2.5	128.5	113.0
2004	3.5	5.9	114.3	97.9	-0.3	3.3	115.0	100.0
2005	11.9	10.1	106.1	87.8	10.7	9.6	104.1	88.9
5-Yr Avg	-3.0	0.2	122.6	102.6	-4.4	-1.9	121.3	103.8
09/2005	6.2	XX	109.1	91.4	XX	XX	XX	XX
09/2006	25.7	XX	93.2	72.2	XX	XX	XX	XX

MEDICUS™
INSURANCE COMPANY

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto or Rate Pages.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practiceConsideration will be given to insureds practicing in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

MARKED CHANGES RECEIVED ON 7-18-07

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate Rate Pages.

XII. PREMIUM PAYMENT PLAN

The Company willmay, at its discretion, offer the insured various premium payment options, outlined on Page 28. Specific options may be referenced in the Rate Pages.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on Page 25the Rate Pages to the premium as shown on the Rate Pages.

D. Premium is fully earned and must be paid, in full within 30 daysaccordance with state statutes, promptly when due.

XVIII. GROUP PRACTICE

For the purpose of the expirationthese rules, group practice shall be defined as a group of the policy entities, physicians, and/or allied health care providers rendering patient care who:

A. The Reporting Period is unlimited.

B. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the terminationNumber 2 or more;

C. Are organized as a legal entity;

D. Share common facilities (including multiple locations) and support personnel.

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XVIIIXIX. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Scheduled Rating is not to be used in conjunction with Loss Rating.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

C. Any exceptions to these rules are contained in the Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured

by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated under B1 or B2 on page 7.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any applicable modifications. However, for groups of 10 or more physicians, the Company may base the maximum premium on the sum of the shareholders' rated classifications.

3. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met. These limits of coverage are shared, unless otherwise specified by endorsement.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the Rate Pages.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27the Rate Pages.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III.A.1 on Page 5:

20% - Separate Corporate Limits

10% - Shared Corporate Limits

Physicians and non Physician Health Care Providers up to 30%

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $1250.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in the Physician/Surgeon and Health Care Provider Section of the Rate Pages. Schedule Rating is not to be used in conjunction with Loss Rating.

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non- physician health care providers.

B. Any exceptions to these rules are contained in the respective Rate Pages.

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II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non- physician health care provider shown on Page 21the Rate Pages, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Classclassification code according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are foundclassification codes will be contained on the Rate Pages 14-19 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manualon the Rate Pages.

2. A Part Time Practitioner may include any practitioner in classes 1 through 3 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated on Page 26in the Rate Pages.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on Page 26the Rate Pages. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to L.57E on page 2620 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on Page 26the Rate Pages.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented on Page 26the Rate Pages.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs. unless stated otherwise in the rule or on the Rate Pages.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated on Page 27the Rate Pages, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27the Rate Pages.

B. Self-Insured Retention Credits

1. Self-Insured Retentions

a. SIR'S shall be offered to qualified insureds, provided the account generates $250,000 or more of manual premium. The eligibility threshold shall be 5

physicians in a medical group. The actual experience of the account will be analyzed and the appropriate credit determined. The items considered in the determination of the applicable credit are: the historical paid frequency; historical paid severity; historical incurred severity; the historical allocated loss adjustment expenses as a percent of indemnity; the processing; acquisition and other expenses associated with the account; the variability of results; the credibility of the experience; the selected deductible annual aggregate; and the loss elimination ratio from the lognormal distribution. The table of SIR's and credits is below:

Per Claim Self Insured Retention	Credit Range As a % of 1M/3M Premium
$100,000	12%8% - 15%
200,000	20%14% - 25%
250,000	22%16% - 28%
500,000	35%26% - 44%
1,000,000	43%31% - 55%

b. SIR's shall be funded at the discretion of the Company, including vehicles such as irrevocable Letters of Credit, Cash or equivalent, or escrow accounts.

c. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

d. SIR's can only be revised at policy renewal.

e. The SIR credits shall apply to the primary limit premium, net of other applicable credits, identified on the Rate Pages.

i. The credits are expressed as a function of the Per Claim limit of liability or per insured and aggregate SIR limit.

ii. The insured may be eligible for an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

C. Experience Rating

Experience Rating is under review. It is currently not available.

D. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided on Page 26 under M.

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

    a. Premiums paid

    b. Number of claims

    c. Paid losses

    d. Paid loss adjustment expenses

    e. Cause of such losses

    f. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

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1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

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2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

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3. The Reporting Period is unlimited.

C. Blending Rates

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A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS 1I

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Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

NON-SURGICAL SPECIALISTS TO INCLUDE:
ACUPUNCTURE, ADMINISTRATIVE MEDICINE, AEROSPACE MEDICINE, ALLERGY AND IMMUNOLOGY, BRONCHO-ESOPHOGOLY, COLONOSCOPY, DENTISTRY (GENERAL), DERMATOLOGY, DIABETES, DISCOGRAM, ENDOCRINOLOGY, FAMILY/GENERAL PRACTICE, FORENSIC MEDICINE, GASTROENTEROLOGY, GYNECOLOGY, HEMATOLOGY, HYPERBARIC MEDICINE, INFECTIOUS DISEASE, INTERNAL MEDICINE, LARYNGOLOGY, NEPHROLOGY, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, ONCOLOGY, OPHTHALMOLOGY, ORTHOPEDICS, OTORHINOLARYNGOLOGY, PAIN MANAGEMENT, PEDIATRICS, PHARMACOLOGY, PHYSIATRY, PHYSICAL MEDICINE & REHAB, PODIATRY, PREVENTATIVE MEDICINE, PSYCHIATRY, PUBLIC HEALTH, PULMONOLOGY, RHEUMATOLOGY, RHINOLOGY, AND UROLOGY.

CLASS 2II

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Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

NON-SURGICAL SPECIALISTS TO INCLUDE:
CARDIOLOGY, GERIATRICS, HOSPITALIST NON-INVASIVE, NEONATOLOGY, NEUROLOGY, PATHOLOGY, RADIOLOGY-READING X-RAYS.

MINOR SURGERY FOR SPECIALISTS TO INCLUDE:
DERMATOLOGY, ENDOCRINOLOGY, FAMILY/GENERAL PRACTICE, GASTROENTEROLOGY, GYNECOLOGY, HEMATOLOGY, INFECTIOUS DISEASE, INTERNAL MEDICINE, LASERS, NEOPLASTIC, NEPHROLOGY, NEUROLOGY, ONCOLOGY, OPHTHALMOLOGY, OTORHINOLARYNGOLOGY, PAIN MANAGEMENT, PATHOLOGY, PEDIATRICS, PULMONOLOGY, UROLOGY

CLASS 3III

Pediatrics-NMRP
Other, Specialty NOC

NON-SURGICAL SPECIALISTS TO INCLUDE: ANESTHESIOLOGY, HOSPITALIST INVASIVE, INTENSIVE CARE MEDICINE , URGENT CARE.

MINOR SURGERY FOR SPECIALISTS TO INCLUDE:
CARDIOLOGY WITH ANGIOGRAPHY, CARDIOLOGY WITH CATHETERIZATION, GERIATRICS, ORTHOPEDICS, RADIATION ONCOLOGY, RADIOLOGY WITH CONTRAST MEDIUM, RADIOLOGY INVASIVE.

MAJOR SURGERY FOR SPECIALISTS TO INCLUDE:
COLON and RECTAL, ENDOCRINOLOGY, GASTROENTEROLOGY, LARYNGOLOGY, NEPHROLOGY, NEONATOLOGY, OPHTHALMOLOGY, ORAL SURGERY, OTOLOGY, OTORHINOLARYNGOLOGY NO PLASTIC, HEAD AND NECK SURGERY NO PLASTIC, PEDIATRICS, RHINOLOGY, UROLOGY.

CLASS 4IV

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine
Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS

Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

SPECIALISTS INCLUDING:
ATTENDING PHYSICIANS EMERGENCY MEDICINE NO SURGERY/MINOR SURGERY, FAMILY/GENERAL PRACTICE WITH MAJOR SURGERY & OB, INCL C-SECTIONS, HOSPITALIST INCL ER, MEDICAL DIRECTOR.

CLASS 5V

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

SURGICAL SPECIALISTS INCLUDING:
CARDIOVASCULAR, CARDIOTHORACIC, GENERAL SURGERY, GYNECOLOGY, HAND SURGERY, NEONATOLOGY, NEOPLASTIC/ ONCOLOGY, ORTHOPEDICS, NO SPINE.

CLASS 6VI

Gynecology-NMRP, NS
Internal Medicine-NMRP
Other, Specialty NOC

SURGICAL SPECIALISTS INCLUDING:
EMERGENCY MEDICINE MAJOR SURGERY, OTORHINOLARYNGOLOGY WITH PLASTIC, PLASTIC SURGERY, THORACIC SURGERY, TRAUMATIC SURGERY, VASCULAR SURGERY.

CLASS 7VII

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

SURGICAL SPECIALISTS INCLUDING:
OBSTETRICS and GYNECOLOGY, PERINATOLOGY, ORTHOPEDIC SURGERY WITH SPINE.

CLASS 8VIII

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS

Otorhinolaryngology-MRP, NMajS
Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery
Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP, Nmaj
Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS
Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery

Otorhinolaryngology; Head/Neck
Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery

Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

SURGICAL SPECIALISTS INCLUDING:

NEUROLOGICAL SURGERY.

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Class 1 – Physician and Surgeon Rate

Psychologist

Class 6 – Physician and Surgeon Rate2

Certified Registered Nurse Anesthetist

Class 13 – Physician and Surgeon Rate5

Certified Nurse Midwife – No complicated OB or surgery

B. Manual Rates

1. Territory Definitions

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TERRITORYAREA 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

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TERRITORYAREA 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORYAREA 3 COUNTIES

Bond, Clinton, Franklin, Hamilton, Jefferson, Washington, Williamson, & Rest of State

AREA 4 COUNTIES

DuPage, Kankakee, Macon and Winnebabo

TERRITORYAREA 5 COUNTIES

Bureau, Lake and Vermillion

AREA 6 COUNTIES

Champaign, Coles, DeKalbBureau, Cole, Dekalb, Effingham, LaSalleLasalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, and Sangamon

TERRITORYAREA 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

Jackson

A. Standard Claims Made Program Step Factors and Mature Rates

a. Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	85%
Fourth Year (Mature):	100%

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b. Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000See Rate Pages

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Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289

4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009

10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Otorhinolaryngology; No Elective Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
12	Emergency Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
15	Orthopaedic Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

3. Mature Rates for non Physician Health Care Providers are calculated as follows:

Class X equals 10% of the Class 1 Physician/Surgeon rate.

Class Y equals 15% of the Class 1 Physician/Surgeon rate.

Class Z equals 25% of the Class 1 Physician/Surgeon rate.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 4 rate.

1. DecreasedIncreased Limit Factors:

Limit	All Classes
1M/3M100/300	1.000
500/1.0200/600	.71991.174
500/1.0	1.500
1M/3M	1.900

2. Extended Reporting Period Coverage Factors:

(1) The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

(2) The Reporting Period is unlimited.

(i) The extended reporting coverage factor is 200%.

(ii) For First Year and Second Year Claims Made steps, it is applied to the annual undiscounted premium at the time of expiration.

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(iii) For Third Year and all years of maturity, it is applied to the mature annual undiscounted premium.

3. Shared Limits Modification:

Not available.

Up to 25%

4. Policy Writing Minimum Premium:

Physicians & Surgeons - $1250.

5. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

6. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: Up to 25% of Class 1

Class Z: 35% of Class 1

7. Premium Modifications

For individual physicians and surgeons:

a. Part Time Physicians & Surgeons – 30%
b. Physicians in Training – 1st Year Residentbased upon hours, up to 50%; Resident 40%; Fellow 30%.
c. Locum Tenens – no premium, subject to prior underwriting approval
d. New Physicians & Surgeons – 30% for the first two years of practice
e. Physician Teaching Specialists – Non-surgicalbased upon hours, up to 50%; Surgical 40%.
f. Physicians Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval

C. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

a. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date.

b. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

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c. If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

d. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

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For Individuals and Groups, subject to Underwriting:

a. Schedule Rating (not to be used in conjunction with Loss Rating)

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1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/- 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+/- 25%

b. Self-Insured Retention Credits for groups, subject to Underwriting

See V.B on Page 11.

c. Experience Rating for groups with at least premium of $100,000 and 5 physicians, subject to Underwriting

Not Available.

d. Slot Rating for groups, subject to Underwriting

See VI.A on Page 13.

D. Mandatory QuarterlyPremium Payment Option.

For medical liability insureds whose annual premiums total $500 or more.

Plan - The Company may, subject to applicable guidelines, offer the insured various premium payment options. The premium payment plan must allow the optionrequires a minimum of quarterly payments.

e. An initial payment 25% of no more than 40%the total premium to be paid on or before the inception/renewal date of the estimated total premium due at policy inception;

f. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

g. No interest charges;

h. Installment charges or. The balance of the premium will be payable in periodic installments. Other fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and

i. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Non-Mandatory Quarterly Payment Option.

e. For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans. apply.

j. For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.

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k. If an insurer offers any quarterly payments under this subsection, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.

Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

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OF COUNSEL:
Bonnie J. Williams – Ext. 201

July 18, 2007

Ms. Gayle Neuman
Property & Casualty Compliance
Illinois Division of Insurance
320 W. Washington Street
Springfield, IL 62704

Re: Medicus Insurance Company Superseded Filings

Dear Ms. Neuman,

The purpose of this letter is the submit the rate, rule, and forms filings which supersede these same filings previously submitted by Medicus Insurance Company. In accordance with the Review Requirements Checklist contained on the Division of Insurance website, my client presents the following:

(1) The name of the advisory organization or company making the filing.
Answer: Medicus Insurance Company

(2) Title, form number, and edition identification of the forms.
Answer: a. Medicus Insurance Company Physicians and Surgeons Liability Policy. IL-001 [Ed. 5/2007].
b. Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers, IL Rate Manual Final [Ed. 061407].

(3) Information as to what Class and Clause coverage is written under.
Answer: Class 2, Clause C medical liability.

(4) Identification of all applicable endorsements and applications as to the policy forms for which the endorsements and applications are used.
Answer: The endorsements are IL-A019, IL-A025, IL-A031, and IL-A035 which apply to Medicus Insurance Company Physicians and Surgeons Liability Policy, IL-001 [Ed. 5/2007]. All endorsements are Edition 5/2007.

(5) Notification as to whether the filing is new or supersedes a present filing.
Answer: The filings supersede all previous filings.

Identification of all changes in all superseding filings as well as identification of all superseded forms is required. The superseded filings and forms are:

a. Medicus Insurance Company Physicians and Surgeons Liability Policy. ILLINOIS POLICY 6001V.1
b. Medicus Insurance Company Physicians and Surgeons Liability Policy. IL-001 [Ed. 032707].
c. Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers, IL Rate Manual Final 122306.
d. Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers, IL Rate Manual Final 032607.
e. Endorsement A019-Cancellation Endorsement 0609.6.
f. Endorsement A025-Extended Reporting Endorsement 0609.6.
g. Endorsement A031-Change of Sole Agent Endorsement 0609.6.
h. Endorsement A035-Excluded Persons or Entities 0609.6.
I. Endorsement A039-Illinois Changes [Ed. 3/2007].

(6) Effective date of use.
Answer: Immediate.

I. Superseded Manual Filing - Showing Changes

The format for this submission is to comport with 50 Ill. Admin. Code 929.30. The document with the most changes is the Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers. Attached in this filing is a "redlined" version which compares the Manual filings for Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers, IL Rate Manual Final [Ed.122306] and Manual Pages for Professional Liability Coverage for Physicians, Surgeons, and Non-Physician Health Care Providers, IL Rate Manual Final [Ed.061407]. The manner for showing the changes is that red font reflects the change for the 061407 version, and blue font is what was changed from the 122306 version which Medicus initially filed.

II. Changes for Endorsements IL A019, A031, and A039 [Ed. 5/2007]

The changes for each endorsement are in yellow highlight with an explanation of the change in italicized parenthesis.

III. The following are your questions presented in an April 11, 2007 electronic mail message and Medicus' answers to the questions.

Question 1. My e-mail dated 3/12/07 asked specific questions about the 2/15/07 filing. In their response however, it is clear that, in addition to answering the specific questions, Medicus made substantive changes to the manual which they failed to identify/disclose. Rule 929.30 [50 Ill. Adm. Code 929.30] requires identification of all changes from superseding filings, and any changes not identified will not be deemed filed. In this case, Medicus didn't even allow for the chance to supersede a filing before they began making substantive changes. However, since substantive changes were implemented well after the original file and use date, please provide a written explanation of all changes made to the filing which were not previously disclosed. Any changes made which are not disclosed will not be deemed filed.

The following examples illustrate some, but not all, of the substantive changes submitted by Medicus in their 4/6/07 response:

(A) The manual submitted on 2/15/07 included 8 physician/surgeon classifications and 6 non-physician classifications. The manual submitted on 4/6/07 included 19 physician/surgeon classifications. When did Medicus begin using the 19 classifications? How many Illinois physicians were written between 2/15/07 and 4/6/07 using these 19 classifications? If any insureds were moved from one of the 8 original classifications to one of the 19 classifications with a lower or higher rate, how was the premium adjusted?
Answer: Medicus began using the 19 classifications on March 12, 2007. Thirteen physicians were written between 2/15/07 and 4/6/07 using these 19 classifications. No insureds were moved from one of the 8 original classifications to one of the 19 classifications, because their classifications were the same in each plan.

Question. (B) The manual submitted on 2/15/07 included 7 territories. The manual submitted on 4/6/07 included 8 territories with some counties moved to a different territory. When did Medicus begin using the different territories? How many Illinois physicians were written between 2/15/07 and 4/6/07 using the 8 territories? If any insureds were in a county that was moved to a different territory, were the premiums reconfigured and any overpayments refunded? What were insureds charged in counties that were not included in the 2/15/07 manual?

It would seem the company was utilizing rates that had not been filed with the Division.
Answer: Medicus began using the different territories on March 12, 2007. Thirteen physicians were written between 2/15/07 and 4/6/07 using the 8 territories. There were no insureds in a county that was moved to a different territory, because their county/territory relationships were the same in each plan.

Question. (C) The manual submitted on 2/15/07 offered 4 limits in the increased limit factors. The manual submitted on 4/6/07 offered only two decreased limit factors. In regard to the increased/decreased limit factors, 1M/3M had a different factor in each filing. In the 2/15/07 filing, the allergy class for Cook County was charged $14,479 for the basic limits of liability of $100,000/$300,000. The 4/6/07 filing charges $14,479 for the $1,000,000/$3,000,000 limits. In the 4/6/07 filing, $100,000/$300,000 limits are not even offered. Please provide explanations similar to the questions posed above regarding how many Illinois policies were issued using the previously-filed limits/rates and how any insureds' accounts will be adjusted if necessary?
Answer: The earlier filing stated 1M/3M at $14,479. Ten policies were written using the previously filed limit/rates. No adjustments are necessary.

Question 2. The rate pages on the previous manual made no clarification for maturity year. It is our position that the manual submitted on 2/15/07 would not allow an agent to correctly quote a premium without inclusion of maturity year factors, unless Medicus does not distinguish between policy maturity years. If the latter is the case, please have Medicus provide a written statement to that effect. Identify the manual.
Answer: Clarification for maturity year was provided in the previous manual on page 13. All doctors written under the previous rate manual were mature.

Question 3. Additional clarifications/corrections to be addressed: On page 1, we requested clarification under IV. Location of Practice in the 3/12/07 e-mail, but nothing was addressed. Please explain the "consideration" to be given to insureds practicing in more than one rating territory. Companies indicate they will rate the person in the higher territory or blend the rates of the applicable territories.
Answer: If 10 percent or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10 percent of an insured's practice is in a higher rated territory, we use the higher rated territory. The rate manual on page 1 paragraph IV of the 061407 edition has been changed to reflect this.

Question. On page 3 under XVII. F, the wording "ERE" is not defined.
Answer: Medicus adjusted the rate manual to reflect "Extended Reporting Endorsement." Pages 3 and 4 of the 061407 edition of the rate manual reflect the change by adding paragraphs E

and F.

Question. On page 8 under III., the premium is shown starting on page 21.
Answer: Medicus has updated the rate manual to show the premium starting on page 21 of the 061407 edition.

Question. On page 10 under F.1., refer to L.5. (delete the "0").
Answer: Medicus adjusted the rate manual to reflect L.5 instead of L.50 on page 10 of the 061407 edition.

Question. On page 12, the table no longer reflects a "range" of credit.
Answer: Medicus adjusted the rate manual to remove the "range" of credit on page 12 of the 061407 edition.

Question. On page 13 under VI. B.1., the end of the first line was discontinued.
Answer: Medicus adjusted the rate manual to correct the end of the first line that was discontinued. Page 12 of the 061407 edition reflects the correction.

Question. On pages 14 through 18, please explain the different classification abbreviations (i.e. NMRP, NS, NOC).
Answer: On page 18 of the 061407 edition Medicus adjusted the rate manual to explain the different classification abbreviations. An explanation of the procedures is NMRP = Nominal Minor Risk Procedure; NS = No Surgery; NOC = Not Otherwise Classified; NMAJS = No Major Surgery; MRP = Minor Risk Procedures; MAJRP = Major Risk Procedures.

Question. On page 19, Class 1, 2 and 5 are listed under Non Physician Health Care Providers. Is there a class 3 and 4? Where are the rates for these classes indicated?
Answer: Yes, there are classes 3 and 4. Pages 21 and 22 of the 061407 edition of the rate manual contain rates for classes 3 and 4.

Question. On page 21, D. should indicate "Mature Rates for Physicians/Surgeons (Claims-made)" as this was how the classifications were titled.
Answer: Page 21 of the 061407 edition of the rate manual contains the new title "Mature Rates for Physicians and Surgeons (Claims made)."

Question. On page 25 under E., it indicates X, Y and Z are a percentage of the Class 1 rate - it should clarify it is the Class 1 Physician/Surgeon Rate as there is also a Class 1 Non-Physician rate, assuming this is the case. This would also require correction on page 26 under K.

Answer: Page 25 of the 061407 edition of the rate manual paragraph E reflects classes X, Y, and Z as a percentage of the Class 1 Physician/Surgeon rate. Page 19 of the 061407 edition explains Classes X, Y, and Z for non-physician healthcare providers. Paragraph K of this same edition includes the word Surgeon.

Question. On page 25, do you no longer offer limits of liability other than the two listed under F.?
Answer: Correct, Medicus offers only two limits of liability.

Question. On page 25, we requested the Shared Limits Modification "up to 25%" be explained in the 3/12/07 e-mail, but nothing was addressed.
Answer: Medicus removed the Shared Limits Modification from the rate manual and will not use it.

Question. On page 26, we requested these clarifications in the 3/12/07 e-mail. Under L. Premium Modifications:
a. 30% - is this a decrease, credit or debit?
b. up to 50% - explain how the exact percentage would be determined.
d. 30% - is this a decrease, credit or debit?
e. up to 50% - explain how the exact percentage would be determined.
Answer: Paragraph IV on pages 8-11 of the 061407 edition of the rate manual describes the various premium modifications for categories of physicians and surgeons to whom the modifications in paragraph L on page 26 apply. In response to your questions: The 30 percent factor applicable to part time physicians & surgeons is a discount. For physicians in training the percentage modification can be up to 50 percent. This particular modification applies to first year residents and many involve residents who are or may not be licensed as physicians depending upon the state statutes. For new physicians & surgeons your question about whether 30 percent is a decrease, credit, or debit, the answer is that it is a decrease. The modification of up to 50 percent for physician teaching specialists is determined based upon the physician being a faculty member of an accredited training program and the coverage to the which the modification applies is only applicable for the teaching activities.

Question. On page 28, explain the references to subsections (e) and (g).
Answer: References to subsections (e) and (g) reflect the requirement in Section 929.30 of the regulations for a quarterly payment option if the annual premium equals $500 or more. The

probability of premiums being less than $500 is unlikely considering the rate tables in the filings do not contemplate a rate this low even when considering rates for non-physicians. However, since Section 929.30 makes the distinction between rates equal to and above $500, Medicus also notes the distinction in the rate filing.

IV. The following are questions presented in your April 12, 2007 electronic mail message and Medicus' answers to the questions.

Question. In regard to the criticisms for forms #A031, #A019, and #A025, the changes were submitted in endorsement form A039. This form is an endorsement amending an endorsement. An endorsement which requires amending must be re-printed. Any form that contains provisions to the contrary is deemed to contain exceptions and conditions that unreasonably or deceptively affect the risks that are purported to be assumed by the policy, pursuant to 215 ILCS 5/143(2).
Answer: In regard to the criticisms for forms A019, A025, A031 and A035, the changes submitted in endorsement A039 have been removed from A039. Further, those changes have now been incorporated directly into the endorsements themselves, and reprinted. Accordingly, enclosed are revised forms A039, A019, A025, A031 and A035 with edition dates of 5/2007.

Question. The policy was given an edition date but there is no form number.
Answer: Policy Edition 5/2007 contains form number IL-001.

Question. On form #A039 under 1, "rescind" should be deleted from the first sentence of the paragraph.
Answer: Medicus deleted "rescind" from the first sentence of paragraph 1 of this endorsement edition [Ed. 5/2007].

Question On form #A039 under 7, "unless the Company offers the insured an alternate plan of payment" should be deleted. The company must offer the quarterly premium installment payment plan to each insured when the policy is issued, and thereafter must provide such plan if it is requested for premiums exceeding $500. This paragraph then continues with "all coverage will expire automatically at the end of the period for which the Company has received payment". The coverage would be automatically renewed if the company failed to issue any notice of renewal or nonrenewal. This paragraph continues with the Company must mail a notice of

renewal with an increase in premium of 30% or more at least 60 days before the renewal date.
Answer: Medicus made the changes to comport with 50 Ill. Adm. Code §929.30 in paragraph 6 in endorsement IL-A039 [Ed. 5/2007].

Question. Under "Renewal" in the policy, delete the wording "in full". This was included in our 3/6/07 e-mail but not addressed.
Answer: Medicus deleted "in full" in the third sentence of the Renewal section of the policy form version IL-001 [Ed. 5/2007].

Question. On form #A039 under 8, you have added language that contradicts language in the policy that you have not deleted. The third paragraph in the policy under the "Cancellation and Non Renewal" should also be deleted.
Answer: The 5/2007 edition of Endorsement A039 references the cancellation and non-renewal provisions in paragraph 5. The changes comport with the requirements of 215 ILCS 5/143.17a.

Question. Intoxicant or narcotic exclusions are prohibited unless they include the following: (1) a standard set forth with regard to what is considered an intoxicant or narcotic; (2) a standard set forth as to what levels of consumption defines intoxication; (3) a standard of proof set forth; and (4) language that distinguishes the intent or motivation. Any forms that contain provisions to the contrary are deemed to contain exceptions and conditions that unreasonably or deceptively affect the risks that are purported to be assumed by the policy, in violation of 215 ILCS 5/143(2) and will be disapproved accordingly. This was included in my 3/29/07 e-mail but not addressed.
Answer: Medicus has removed Exclusion 11 regarding intoxicants and narcotics in its entirety from endorsement IL A0-39 [Ed. 5/2007].

Question. In regard to the vicarious liability issue, we have additional questions. On form A035, please explain generally what will be inserted into the blanks. The second blank appears to be for listing individuals/entities that will be excluded. Is blank one for a type of treatment, like for example gastric bypass? Please explain this further. This was included in my 3/29/07 e-mail but not addressed.
Answer: The first paragraph relates to acts or conduct that are outside the scope of providing professional services during which a medical incident may occur and does not refer to a type of

treatment. The second paragraph refers to individuals, entities, employees, or agents of the insured.

Thank you for your consideration and if you have any questions or comments, please call 525-0700 Ext. 108 or via email at *skinion@601w.com*

Sincerely,

Steve W. Kinion

Table of Contents
for Policy and Rate, Rule, and Form Filing
for Medicus Insurance Company

July 19, 2007

Tab

Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Friday, June 01, 2007 1:45 PM
To: Neuman, Gayle
Subject: Medicus Rates, Rules, and Form Filing

Gayle

To follow up on our telephone conversation of last week during which I said that I would submit the changed filing with an explanation of changes this week. My intent was to do so today, but unfortunately that will not be possible. I am working to make the explanation of changes as clear and easy to follow as possible in order to make your job easier and comport with Rule 929.30. My effort for detail of clarity will cause me to submit the filing next week. I am on my way to San Francisco for the NAIC meeting and will work on this matter while there. My hope is that this does not inconvenience you.

Thanks
Steve

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Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Saturday, May 19, 2007 6:11 PM
To: Neuman, Gayle
Subject: Re: Medicus - Rate/Rule Filing #2007-R and Form Filing #2007-F

Gayle,

I am preparing the response for submission to you next week.

Thanks
Steve

----- Original Message -----
From: Neuman, Gayle
To: Steve Kinion
Sent: Wednesday, May 16, 2007 10:20 AM
Subject: Medicus - Rate/Rule Filing #2007-R and Form Filing #2007-F

Mr. Kinion,

To my knowledge, we have not received a response from Medicus regarding the 4/11/07 rate/rule criticisms or to the 4/12/07 form filing criticisms. If a response was provided, please indicate the date and I will search my inbox.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Tuesday, April 17, 2007 1:21 PM
To: Neuman, Gayle
Cc: Bruce Arnold
Subject: Fw: IL Rating rule answers Filing #2007-R

Attachments: IL DOI Rating Rules Answers 032507.pdf

L DOI Rating Rules Answers 03...

Gayle,

The attached pdf file addresses the questions you raised in your March 12 message regarding Rate/Rule Filing #2007-R. Due to a mistake on my part, not Medicus', these answers were not sent to you in a timely manner. My only defense is that this file was originally submitted to me in a file format I could not open. The inability to open the file resulted in confusion on my part which caused me not include these answers in the amended filing. Earlier today Bruce Arnold and I were reviewing you email questions and I realized that Medicus had addressed your answers, but you did not have those answers.

Please accept my sincerest apologies for this oversight,

Steve Kinion

----- Original Message -----
From: "Bruce Arnold" <barnold@medicusins.com>
To: "Steve Kinion" <skinion@601w.com>
Sent: Tuesday, April 17, 2007 12:50 PM
Subject: IL Rating rule answers

-----Original Message-----
From: "Neuman, Gayle" <Gayle.Neuman@illinois.gov>
Date: Mon, 12 Mar 2007 13:27:08
To:<skinion@601w.com>
Subject: Medicus Insurance Company - Rate/Rule Filing #2007-R

Mr. Kinion,

We are in receipt of the above referenced filing submitted on February 15, 2007. Please address the following issues:

1. On the pages labeled "Illinois Rates" with the appropriate counties listed underneath, there is no information provided to indicate the applicable limits of liability or maturity year.

Answer: The referenced pages in the Illinois Rate Manual have been adjusted to indicate the applicable limits of liability and maturity year.

2. In Section I General Rules under IV. Location of Practice, please explain the "consideration" to be given to insureds practicing in more than one rating territory.

Answer: In general, the higher rated territory will determine the premium to be charged. However, the Underwriter may use reasonable judgment in applying this principle. For example, if an insured practices 10% or less in a higher rated territory, the Underwriter may choose to determine the premium based upon the lower rated territory because it comprises the vast majority of the exposure.

3. In Section I General Rules under XI. Policy Minimum Premium, the manual references "associated coverages". Is this for non-physician healthcare providers? Please explain.

Answer: Professional Liability, including physicians, surgeons and non-physician healthcare providers, is the only type of insurance coverage contemplated in this Filing. Accordingly, the reference to "associated coverages" has been removed.

4. In Section I General Rules under XI. Premium Payment Plan (page 3) and on page 21, the premium payment plan is referenced. The company is required to offer to all insureds whose premium exceeds $500 a quarterly installment payment plan. The wording provided indicates "at its discretion" - this wording should be deleted, or changed to indicate it applies to a payment plan other than the quarterly installment plan required. Specific options SHALL be referenced in the Rate Pages or MANUAL. Additionally, wording indicates various payment plans are offered. We require all payment plans be disclosed in the manual, in

addition to the required quarterly installment plan. All fees or interest charged should be disclosed in the manual. Additionally, we require the filing specifically indicate:

a. An initial down-payment of no more than 40% of the estimated total premium due at policy inception;

b. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

c. No interest charges;

d. Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

e. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

f. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. However, if offered to either, the plan must be made available to all within that group. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement.

Answer: The referenced pages in the Rate Manual have been corrected to offer a premium payment plan as mandatory and not discretionary. Further, the premium payment plan complies with the Illinois requirement, and is conveyed in Section III on page 28.

5. In Section I General Rules XVIII. Group Practice, please explain the difference between group practice and Section II Corporations, Partnerships and Associations?

Answer: Section I, Rule XVIII is removed in its entirety from the Rate Manual. Section II comprises the rating rules for group practices.

6. In Section II under V. Premium Modifications, B. Manual Rates, please explain "Physicians and non Physician Health Care Providers up to 30%".

Answer: Clarity has been provided in Section II.V.B.

7. In Section III under IV. Classifications, F. Physician Teaching Specialists, paragraph 1. a. references 7E on page 20 - it should be page 19.

Answer: Reference has been corrected to Page number 26.

8. There are numerous places in this filing that reference information is presented on the "Rate Pages". This reference should actually state the manual or rule pages as the pages with the rates do not provide any other information.

Answer: References to "Rate Pages" have been adjusted to refer to actual manual or rule pages.

9. In Section III under V. Premium Modifications, B. Self-Insured Retention Credits, please explain the range of the credits for the different self-insured retention amounts. Can two different insureds each with a $100,000 retention receive a different credit percentage? Please explain.

Answer: Ranges of Self-Insured Retention credits have been replaced with fixed percentages for Self-Insured retentions. Insureds each with a $100,000 retention would receive the same credit percentage.

10. We don't understand the outlining order of the manual starting at page 14.

Answer: The outlining order of the Rate Manual starting on page 14 has been re-numbered for clarity.

11. On page 17, under Territory Definitions, does Medicus only write in the counties listed? There is no reference to "remainder of the State" for any counties not listed. Winnebago County is misspelled.

Answer: No. "Remainder of State" has been moved into its own Territory 8. The spelling of Winnebago County has been corrected.

12. On page 18 under 2. Extended Reporting Period Coverage Factors, it should indicate the extended reporting period premium on a professional liability policy will be priced as a factor of (1) the last 12 months' premium, (2) the premium in effect at policy issuance, or (3) the expiring annual premium. The manual fails to indicate if the extended reporting period is for 12 months, unlimited, or other. This should also be clarified on page 14 under the requirements for waiver of premium. The manual also fails to indicate the insured has at least 30 days after the policy is terminated to purchase the extended reporting period, and that it must be offered regardless of the reason

for termination. The company must inform the insured of the extended reporting period premium at the time the last policy is purchased.

Answer: This provision has been moved to Page 25, under G. The extended reporting period premium on a professional liability policy will be priced as a factor of the expiring annual premium. Since this provision represents a significant reduction in ERE pricing, we are partially offsetting the reduction by adopting a sliding range of factors, from ISMIE's approved filing. The manual indicates the reporting period is unlimited. This is also clarified on Page 14. The Manual now indicates that the Insured has 30 days after the policy's termination to purchase the extended reporting period. The ERE must be offered regardless of the reason for the termination.

13. On page 18 under 3. Shared Limits Modification and on page 19 under 6. Separate Limits for Non-Physician Healthcare Providers Modification, each state "up to 25%" - please explain how the exact percentage would be determined.

Answer: With respect to the reference to Page 18 under 3, please note this has been re-numbered to III.H on Page 25. We are restricting shared limits modifications to 25%, which is the maximum limit in many states. In unique situations, it is to the advantage of the market and the insured physicians to have a flexible rating plan when the manual rates produce unfair results. These situations don't arise unless the applicant has some credibility of its own. With respect to the reference to Page 19 under 6, re-numbered to III.K on Page 26, we are limiting modifications for separate limits for non-physician healthcare providers to 20%, 25% and 35% of Class X, Y and Z, respectively.

14. On page 19 under 7. Premium Modifications:
    a. 30% - is this a decrease, credit or debit?
    b. up to 50% - explain how the exact percentage would be determined.
    d. 30% - is this a decrease, credit or debit?
    e. up to 50% - explain how the exact percentage would be determined.

Answer: Please note this item has been re-numbered and moved to Page 26:
    L.1 – 30%, this is a decrease.
    L.2 – 1st Year Resident, 50%; Resident, 40%; Fellow, 30%.
    L.4 – 30%, this is a decrease.
    L.5 – Non-surgical, 50%; Surgical, 40%.

15. On page 21 under c., what is the amount of the discount (decrease, credit or debit)?

Answer: We are finalizing an Experience Rating Plan for our Illinois business we intend to file in the near future. In the meantime, we do not plan to use an

Experience Rating Plan for accounts in Illinois.

16. Pursuant to 50 Ill. Adm. Code 929, new insurers are required to file a statement indicating whether the company will report its medical liability statistics to a statistical agent (and if so, which one) or it the company has its own plan for the gathering of medical liability statistics. The Director, at any time, may request a copy of the company's statistical plan or request the company to provide written verification of membership and reporting status from the company's statistical agency.

Answer: We have our own plan for the gathering of medical liability statistics, and will report accordingly.

17. All rate/rule filings must be accompanied by a statement indicating that the company, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

Answer: Medicus Insurance Company affirms that we do not unfairly discriminate in offering, administering, or applying the filed rate/rule manual and/or any amended provisions.

We request receipt of your response by March 22, 2007.

Gayle Neuman

Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Neuman, Gayle

From: Neuman, Gayle
Sent: Wednesday, April 11, 2007 3:18 PM
To: 'Steve Kinion'
Subject: Medicus Insurance Company - Rate/Rule Filing #2007-R

Mr. Kinion,

We have reviewed the response submitted on April 6, 2007 and the company's letter to you dated April 9, 2007. We would like to discuss this with you and Medicus as early as possible by conference call. As you can see, we have many questions about Medicus' use of non-filed rates/rules. A company's use of non-filed rates/rules is a very serious issue, which is why we think it would be helpful to have a conference call as soon as possible to determine whether Medicus was, in fact, using non-filed manuals, and to finalize this filing since Medicus is already attempting to make substantive changes.

The rating manual discussed in the April 9, 2007 letter was not accidentally sent to us by Medicus. We received a copy of the manual from another source who obtained it from an agent to whom it had been distributed. The Division of Insurance had received more than one inquiry regarding this issue from different parties.

Please address the issue of some (all?) Illinois agents using a manual and rates/rules that had not been filed in Illinois, including whether Illinois-filed manuals have now been correctly distributed, when they were distributed, and how many Illinois policies were rated using the non-filed Missouri rate/rule pages.

In addition, please address the following:

1. My e-mail dated 3/12/07 asked specific questions about the 2/15/07 filing. In their response however, it is clear that, in addition to answering the specific questions, Medicus made substantive changes to the manual which they failed to identify/disclose. Rule 929.30 [50 Ill. Adm. Code 929.30] requires identification of all changes from superseding filings, and any changes not identified will not be deemed filed. In this case, Medicus didn't even allow for the chance to supersede a filing before they began making substantive changes. However, since substantive changes were implemented well after the original file and use date, please provide a written explanation of all changes made to the filing which were not previously disclosed. Any changes made which are not disclosed will not be deemed filed.

The following examples illustrate some, but not all, of the substantive changes submitted by Medicus in their 4/6/07 response:

A) The manual submitted on 2/15/07 included 8 physician/surgeon classifications and 6 non-physician classifications. The manual submitted on 4/6/07 included 19 physician/surgeon classifications. When did Medicus begin using the 19 classifications? How many Illinois physicians were written between 2/15/07 and 4/6/07 using these 19 classifications? If any insureds were moved from one of the 8 original classifications to one of the 19 classifications with a lower or higher rate, how was the premium adjusted?

B) The manual submitted on 2/15/07 included 7 territories. The manual submitted on 4/6/07 included 8 territories with some counties moved to a different territory. When did Medicus begin using the different territories? How many Illinois physicians were written between 2/15/07 and 4/6/07 using the 8 territories? If any insureds were in a county that was moved to a different territory, were the premiums reconfigured and any overpayments refunded? What were insureds charged in counties that were not included in the 2/15/07 manual? It would seem the company was utilizing rates that had not been filed with the Division.

C) The manual submitted on 2/15/07 offered 4 limits in the increased limit factors. The manual submitted on 4/6/07 offered only two decreased limit factors. In regard to the increased/decreased limit factors, 1M/3M had a different factor in each filing. In the 2/15/07 filing, the allergy class for Cook County was charged $14,479 for the basic limits of liability of $100,000/$300,000. The 4/6/07 filing charges $14,479 for the $1,000,000/$3,000,000 limits. In the 4/6/07 filing, $100,000/$300,000 limits are not even offered. Please provide explanations similar to the questions posed above regarding how many Illinois policies were issued using the previously-filed limits/rates and how any insureds' accounts will be adjusted if necessary?

2. The rate pages on the previous manual made no clarification for maturity year. It is our position that the manual submitted on 2/15/07 would not allow an agent to correctly quote a premium without inclusion of maturity year factors, unless Medicus does not distinguish between policy maturity years. If the latter is the case, please [illegible]

a written statement to that effect.

3. Additional clarifications/corrections to be addressed:

On page 1, we requested clarification under IV. Location of Practice in the 3/12/07 e-mail, but nothing was addressed. Please explain the "consideration" to be given to insureds practicing in more than one rating territory. Companies indicate they will rate the person in the higher territory or blend the rates of the applicable territories.
On page 3 under XVII. F, the wording "ERE" is not defined.
On page 8 under III., the premium is shown starting on page 21.
On page 10 under F.1., refer to L.5. (delete the "0").
On page 12, the table no longer reflects a "range" of credit.
On page 13 under VI. B.1., the end of the first line was discontinued.
On pages 14 through 18, please explain the different classification abbreviations (i.e. NMRP, NS, NOC).
On page 19, Class 1, 2 and 5 are listed under Non Physician Health Care Providers. Is there a class 3 and 4? Where are the rates for these classes indicated?
On page 21, D. should indicate "Mature Rates for Physicians/Surgeons (Claims-made)" as this was how the classifications were titled.
On page 25 under E., it indicates X, Y and Z are a percentage of the Class 1 rate - it should clarify it is the Class 1 Physician/Surgeon Rate as there is also a Class 1 Non-Physician rate, assuming this is the case. This would also require correction on page 26 under K.
On page 25, do you no longer offer limits of liability other than the two listed under F.?
On page 25, we requested the Shared Limits Modification "up to 25%" be explained in the 3/12/07 e-mail, but nothing was addressed.
On page 26, we requested these clarifications in the 3/12/07 e-mail. Under L. Premium Modifications:

a. 30% - is this a decrease, credit or debit?
b. up to 50% - explain how the exact percentage would be determined.
d. 30% - is this a decrease, credit or debit?
e. up to 50% - explain how the exact percentage would be determined.

On page 28, explain the references to subsections (e) and (g).

Please contact me to set up a time for the conference call.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/ <http://www.idfpr.com/>) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Tuesday, April 10, 2007 12:01 PM
To: Neuman, Gayle
Subject: Re: Medicus - rate/rule manual inquiry
Attachments: Medicus Illinois Rule Explanation Letter.pdf

Gayle,

Attached is the explanation for the manual distributed to Illinois agents. I am also still grappling with the question of the extended reporting endorsement. I presume when you question the ERE, you are referring to Section 143?

Thanks
Steve

----- Original Message -----
From: Neuman, Gayle
To: Steve Kinion
Sent: Tuesday, April 10, 2007 11:12 AM
Subject: FW: Medicus - rate/rule manual inquiry

Mr. Kinion,

I have not had time yet to review the response provided on the rate/rule filing. However, I was wondering what Medicus' response was regarding the attached e-mail which includes a copy of a manual that was distributed to Illinois agents. Please forward a response to this issue by April 17, 2007.

From: Neuman, Gayle
Sent: Thursday, March 22, 2007 8:37 AM
To: 'Steve Kinion'
Subject: Medicus - rate/rule manual inquiry

Mr. Kinion,

Attached is a copy of the manual we are inquiring about. Thank you for your assistance.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

MEDICUS™
INSURANCE COMPANY

April 9, 2007

Mr. Steve Kinion
Zack Stamp, Ltd.
601 W. Monroe Street
Springfield, IL 62704

RE: Rate/Rule Manual Inquiry

Dear Mr. Kinion:

Further to Ms. Gayle Neuman's e-mail to you dated March 22, 2007, please be advised that I have determined the cause of the inaccurate Rate Manual that was inadvertently sent out from our office, and received by Ms. Neuman at the Illinois Division of Insurance.

As you recall, the Rate Manual in question contained Missouri information by mistake. This was a clerical error. The Rate Manual in question was in process of being conformed to Illinois, and one of several drafts was inadvertently released before it was completed. The mistake was caught afterward, and the correct Manual was sent with notification of the error.

We have implemented internal controls to prevent this from happening in the future. The controls have been submitted to individuals at Medicus who come in contact with our Illinois business. These individuals are now required, with respect to any rate or form documents pertaining to Illinois, to run them past me personally before releasing them outside our office.

We sincerely regret this error, and apologize for any inconvenience it may have caused. Thank you in advance for accepting our explanation of this matter.

Please do not hesitate to contact me should there be further questions, or if I can provide any additional information.

Sincerely,

Bruce Arnold
Vice President

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OF COUNSEL:
Bonnie J. Williams – Ext. 201

April 5, 2007

Ms. Gayle Neuman
Division of Insurance
Illinois Department of Financial and Professional Regulation
320 W. Washington Street
Springfield, IL 62767-0001

Re: Medicus Insurance Company
Submission of Rates, Rules, and Forms - Medical Malpractice Coverage
Rate/Rule Filing No. 2007-MR
Form Filing No. 2007-F

Dear Ms. Neuman:

The purpose of this letter is to present the revised rate, rule, and form filings for Medicus Insurance Company. The revisions are the product of the comments and questions you presented in your electronic mail messages. Since tomorrow is the deadline for presenting these filings I am having these delivered to you on Friday. There is one lingering question that we have pertaining to question 12 in your March 12 electronic mail message. I have attached this message to this letter. If there are corrections to be made to the filing regarding this question, I believe we can quickly address these.

Thank you for your assistance.

Sincerely,

Steve W. Kinion

cc: Bruce Arnold, Medicus Insurance Company

Richard J. Roth, Jr.
Consulting Casualty Actuary

Fellow, Casualty Actuarial Society
Fellow, Conference of Consulting Actuaries

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Web site: www.bickwhat.com

March 12, 2007

Mr. Michael T. McRaith, Director
Illinois Division of Insurance
320 West Washington Street
Springfield, IL 62767

Re: Rate filing for Medicus Insurance Company (medical malpractice)

Dear Director McRaith:

On January 17, 2007, I wrote an Opinion Letter in connection with the filing of medical malpractice rates for the Medicus Insurance Company.

Those rates were organized alphabetically by specialty. The company would like to refile the rates showing the rates grouped by Classes of physicians by Territory, as used by ISMIE Mutual.

These new rates were obtained from a copy of the ISMIE Mutual Insurance Company Rate and Rule Filing Effective July 1, 2006, which were then deviated downward 10% to get the Medicus proposed rates. We have matched precisely the ISMIE Rate Class Plan, less 10% across the board. Any differences in these rates from the rates which we previously filed are due to the differences in ISMIE Mutual's July 1, 2006, filing.

All of the comments that I made in the January 17, 2007, letter apply here as well.

In the future, rate changes will be filed based on the experience of Medicus, to the extent that the experience is credible.

Sincerely,

Richard J. Roth Jr.

Richard J. Roth Jr.
Bickerstaff, Whatley, Ryan & Burkhalter

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company will offer the insured premium payment options, outlined on Page 28.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on Page 25.

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The ERE must be offered regardless of the reason for the termination.

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Scheduled Rating is not to be used in conjunction with Loss Rating.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated under B1 on page 7.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any applicable modifications. However, for groups of 10 or more physicians, the Company may base the maximum premium on the sum of the shareholders' rated classifications.

3. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met. These limits of coverage are shared, unless otherwise specified by endorsement.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company,

uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III.A.1 on Page 5:

20% - Separate Corporate Limits

10% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $1250.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Schedule Rating is not to be used in conjunction with Loss Rating.

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non-physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown on Page 21, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found on Pages 14-19 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

2. A Part Time Practitioner may include any practitioner in classes 1 through 3 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated on Page 26.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on Page 26. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to L.50. on page 26 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on Page 26.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented on Page 26.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated on Page 27, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Self-Insured Retention Credits

1. Self-Insured Retentions

a. SIR'S shall be offered to qualified insureds, provided the account generates $250,000 or more of manual premium. The eligibility threshold shall be 5 physicians in a medical group. The actual experience of the account will be analyzed and the appropriate credit determined. The items considered in the

determination of the applicable credit are: the historical paid frequency; historical paid severity; historical incurred severity; the historical allocated loss adjustment expenses as a percent of indemnity; the processing; acquisition and other expenses associated with the account; the variability of results; the credibility of the experience; the selected deductible annual aggregate; and the loss elimination ratio from the lognormal distribution. The table of SIR's and credits is below:

Per Claim Self Insured Retention	Credit Range As a % of 1M/3M Premium
$100,000	12%
200,000	20%
250,000	22%
500,000	35%
1,000,000	43%

b. SIR's shall be funded at the discretion of the Company, including vehicles such as irrevocable Letters of Credit, Cash or equivalent, or escrow accounts.

c. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

d. SIR's can only be revised at policy renewal.

e. The SIR credits shall apply to the primary limit premium, net of other applicable credits.

i. The credits are expressed as a function of the Per Claim limit of liability or per insured and aggregate SIR limit.

ii. The insured may be eligible for an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

C. Experience Rating

Experience Rating is under review. It is currently not available.

D. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided on Page 26 under M.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of d
death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine
Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP

Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS

Otorhinolaryngology-MRP, NMajS
Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery

Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP, Nmaj
Otorhinolaryngology; No Elective Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS
Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery

Otorhinolaryngology; Head/Neck
Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

Neurosurgery
Other, Specialty NOC

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Class 1

Psychologist

Class 2

Certified Registered Nurse Anesthetist

Class 5

Certified Nurse Midwife – No complicated OB or surgery

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	85%
Fourth Year (Mature):	100%

D. Mature Rates for Physicians (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289

4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009

10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Otorhinolaryngology; No Elective Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
12	Emergency Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
15	Orthopaedic Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

E. Mature Rates for non Physician Health Care Providers

Class X equals 10% of the Class 1 rate.

Class Y equals 15% of the Class 1 rate.

Class Z equals 25% of the Class 1 rate.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 4 rate.

F. Decreased Limit Factors:

Limit	All Classes
1M/3M	1.000
500/1.0	.7199

G. Extended Reporting Period Coverage Factors:

(1) The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

(2) The Reporting Period is unlimited.

H. Shared Limits Modification:

Up to 25%

I. Policy Writing Minimum Premium:

Physicians & Surgeons - $1250.

J. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

K. Separate Limits for Non-Physician Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

L. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – based upon hours, up to 50%
3. Locum Tenens – no premium, subject to prior underwriting approval
4. New Physicians & Surgeons – 30% for the first two years of practice
5. Physician Teaching Specialists – based upon hours, up to 50%
6. Physicians Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval

M. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

(i) If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date.

(ii) If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

(iii) If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

(iv) If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

N. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.
Maximum Modification	+/- 25%

O. Self-Insured Retention Credits for groups, subject to Underwriting

See V.B on Page 11.

P. Experience Rating

Not Available.

Q. Slot Rating for groups, subject to Underwriting

See VI.A on Page 13.

R. Mandatory Quarterly Payment Option.

For medical liability insureds whose annual premiums total $500 or more, the plan must allow the option of quarterly payments.

(v) An initial payment of no more than 40% of the estimated total premium due at policy inception;

(vi) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

(vii) No interest charges;

(viii) Installment charges or fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and

(ix) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Non-Mandatory Quarterly Payment Option.

(x) For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans.

(xi) For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.

(xii) If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.

Quarterly installment premium payment plans subject to (e) or (g) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

Richard J. Roth, Jr.
Consulting Casualty Actuary

Fellow, Casualty Actuarial Society
Fellow, Conference of Consulting Actuaries

Bickerstaff, Whatley, Ryan & Burkhalter, Inc.
8821 Baywood Drive
Huntington Beach, California 92646

Phone: 714-964-7814
Fax: 714-964-2896
E-mail: rothjr@ix.netcom.com
Web site: www.bickwhat.com

March 21, 2007

Mr. Michael T. McRaith, Director
Illinois Division of Insurance
320 West Washington Street
Springfield, IL 62767

Re: Rate filing for Medicus Insurance Company (medical malpractice) – Claim Free Credit Discount

Dear Director McRaith:

On January 17, 2007, and March 12, 2007, I wrote Opinion Letters in connection with the filing of medical malpractice rates for the Medicus Insurance Company. This letter is in regard to a further modification of the rates.

As a new insurer, Medicus Insurance Company is in the process of developing its program to conform to the marketplace in Illinois.

In order to be competitive for the very good doctors with claim free experience for many years, Medicus would like to offer a Claim Free Credit Discount, which is described in this filing.

I see no actuarial problem with this discount, and it would not result in rates which are inadequate or unfairly discriminatory.

All of the comments that I made in the January 17, 2007, and March 12, 2007, letters apply here as well.

Sincerely,

Richard J. Roth Jr.

Richard J. Roth Jr.
Bickerstaff, Whatley, Ryan & Burkhalter

Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Thursday, April 05, 2007 12:53 PM
To: Neuman, Gayle
Subject: Re: Medicus Insurance Company - Rate/Rule Filing #2007-R

Gayle,

Almost ready to submit Medicus' rate, rule, and form filing. I have one last question, about your comment below which I have noted in bold. Does your comment mean that if the policy is cancelled on 4/1/07 and the insured purchases Extended Reporting Endorsement then Medicus would have to inform the insured of the extended reporting period premium on 4/1/06 which is the date coverage begins?

12. On page 18 under 2. Extended Reporting Period Coverage Factors, it should indicate the extended reporting period premium on a professional liability policy will be priced as a factor of (1) the last 12 months' premium, (2) the premium in effect at policy issuance, or (3) the expiring annual premium. The manual fails to indicate if the extended reporting period is for 12 months, unlimited, or other. This should also be clarified on page 14 under the requirements for waiver of premium. The manual also fails to indicate the insured has at least 30 days after the policy is terminated to purchase the extended reporting period, and that it must be offered regardless of the reason for termination. **The company must inform the insured of the extended reporting period premium at the time the last policy is purchased.**

Thanks,

Steve Kinion

STEVE W. KINION
ZACK STAMP, LTD.
ATTORNEYS AT LAW
601 W. MONROE STREET
SPRINGFIELD, IL 62704
217-525-0700 EXT. 108
217-220-0035 CELLULAR
217-525-0780 FAX
SKINION@601W.COM
WWW.ZACKSTAMP.NET

----- Original Message -----
From: Neuman, Gayle
To: skinion@601w.com
Sent: Monday, March 12, 2007 1:27 PM
Subject: Medicus Insurance Company - Rate/Rule Filing #2007-R

Mr. Kinion,

We are in receipt of the above referenced filing submitted on February 15, 2007. Please address the following issues:

1. On the pages labeled "Illinois Rates" with the appropriate counties listed underneath, there is no information provided to indicate the applicable limits of liability or maturity year.

2. In Section I General Rules under IV. Location of Practice, please explain the "consideration" to be given to insureds practicing in more than one rating territory.

3. In Section I General Rules under XI. Policy Minimum Premium, the manual references "associated coverages". Is this for non-physician healthcare providers? Please explain.

4. In Section I General Rules undes XI. Premium Payment Plan (page 3) and on page 21, the premium payment plan is referenced. The company is required to offer to all insureds whose premium exceeds $500 a quarterly installment payment plan. The wording provided indicates "at its discretion" - this wording should be deleted, or changed to indicate it applies to a payment plan other than the quarterly installment plan required. Specific options SHALL be referenced in the Rate Pages or MANUAL. Additionally, wording indicates various payment plans are offered. We require all payment plans be disclosed in the manual, in addition to the required quarterly installment plan. All fees or interest charged should be disclosed in the manual. Additionally, we require the filing specifically indicate:

a. An initial downpayment of no more than 40% of the estimated total premium due at policy inception;

b. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at

30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

c. No interest charges;

d. Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

e. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments,

if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a

separate transaction.

f. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual

premiums are less than $500, or for premium for any extension of a reporting period. However, if offered to either, the plan must be made

available to all within that group. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of

the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan,

but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment

plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially

similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies

with this requirement.

5. In Section I General Rules XVIII. Group Practice, please explain the difference between group practice and Section II Corporations, Partnerships and Associations?

6. In Section II under V. Premium Modifications, B. Manual Rates, please explain "Physicians and non Physician Health Care Providers up to 30%".

7. In Section III under IV. Classifications, F. Physician Teaching Specialists, paragraph 1. a. references 7E on page 20 - it should be page 19.

8. There are numerous places in this filing that reference information is presented on the "Rate Pages". This reference should actually state the manual or rule pages as the pages with the rates do not provide any other information.

9. In Section III under V. Premium Modifications, B. Self-Insured Retention Credits, please explain the range of the credits for the different self insured retention amounts. Can two different insureds each with a $100,000 retention receive a different credit percentage? Please explain.

10. We don't understand the outlining order of the manual starting at page 14.

11. On page 17, under Territory Definitions, does Medicus only write in the counties listed? There is no reference to "remainder of the State" for any counties not listed. Winnebago County is misspelled.

12. On page 18 under 2. Extended Reporting Period Coverage Factors, it should indicate the extended reporting period premium on a professional liability policy will be priced as a factor of (1) the last 12 months' premium, (2) the premium in effect at policy issuance, or (3) the expiring annual premium. The manual fails to indicate if the extended reporting period is for 12 months, unlimited, or other. This should also be clarified on page 14 under the requirements for waiver of premium. The manual also fails to indicate the insured has at least 30 days after the policy is terminated to purchase the extended reporting period, and that it must be offered regardless of the reason for termination. The company must inform the insured of the extended reporting period premium at the time the last policy is purchased.

13. On page 18 under 3. Shared Limits Modification and on page 19 under 6. Separate Limits for Non-Physician Healthcare Providers Modification, each state "up to 25%" - please explain how the exact percentage would be determined.

14. On page 19 under 7. Premium Modifications:
    a. 30% - is this a decrease, credit or debit?
    b. up to 50% - explain how the exact percentage would be determined.
    d. 30% - is this a decrease, credit or debit?
    e. up to 50% - explain how the exact percentage would be determined.

15. On page 21 under c., what is the amount of the discount (decrease, credit or debit)?

16. Pursuant to 50 Ill. Adm. Code 929, new insurers are required to file a statement indicating whether the company will report its medical liability statistics to a statistical agent (and if so, which one) or it the company has its own plan for the gathering of medical liability statistics. The Director, at any time, may request a copy of the company's statistical plan or request the company to provide written verification of membership and reporting status from the company's statistical agency.

17. All rate/rule filings must be accompanied by a statement indicating that the company, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

We request receipt of your response by March 22, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation

(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Neuman, Gayle
Sent: Thursday, March 22, 2007 11:50 AM
To: 'Steve Kinion'
Subject: RE: Medicus - rate/rule manual inquiry

Steve,

That is fine.

From: Steve Kinion [mailto:skinion@601w.com]
Sent: Thursday, March 22, 2007 11:44 AM
To: Neuman, Gayle
Subject: Re: Medicus - rate/rule manual inquiry

Gayle,

Thank you very much and I will begin reviewing it. On Monday and Tuesday of next week I will be in Austin meeting with Medicus' staff about this particular inquiry as well as the rates, rules, and forms we submitted earlier. You kindly allowed us an extension until March 27 to respond to your questions about the forms. Is it permissible to get an extension on the rate and rule filing to March 27 as well? I can call if you would like an additional explanation.

Thanks,
Steve

----- Original Message -----
From: Neuman, Gayle
To: Steve Kinion
Sent: Thursday, March 22, 2007 7:36 AM
Subject: Medicus - rate/rule manual inquiry

Mr. Kinion,

Attached is a copy of the manual we are inquiring about. Thank you for your assistance.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, March 12, 2007 1:27 PM
To: 'skinion@601w.com'
Subject: Medicus Insurance Company - Rate/Rule Filing #2007-R

Mr. Kinion,

We are in receipt of the above referenced filing submitted on February 15, 2007. Please address the following issues:

1. On the pages labeled "Illinois Rates" with the appropriate counties listed underneath, there is no information provided to indicate the applicable limits of liability or maturity year.

2. In Section I General Rules under IV. Location of Practice, please explain the "consideration" to be given to insureds practicing in more than one rating territory.

3. In Section I General Rules under XI. Policy Minimum Premium, the manual references "associated coverages". Is this for non-physician healthcare providers? Please explain.

4. In Section I General Rules undes XI. Premium Payment Plan (page 3) and on page 21, the premium payment plan is referenced. The company is required to offer to all insureds whose premium exceeds $500 a quarterly installment payment plan. The wording provided indicates "at its discretion" - this wording should be deleted, or changed to indicate it applies to a payment plan other than the quarterly installment plan required. Specific options SHALL be referenced in the Rate Pages or MANUAL. Additionally, wording indicates various payment plans are offered. We require all payment plans be disclosed in the manual, in addition to the required quarterly installment plan. All fees or interest charged should be disclosed in the manual. Additionally, we require the filing specifically indicate:

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b. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at

30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

c. No interest charges;

d. Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

e. A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments,

if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a

separate transaction.

f. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual

premiums are less than $500, or for premium for any extension of a reporting period. However, if offered to either, the plan must be made

available to all within that group. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of

the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan,

but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment

plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially

similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies

with this requirement.

5. In Section I General Rules XVIII. Group Practice, please explain the difference between group practice and Section II Corporations, Partnerships and Associations?

6. In Section II under V. Premium Modifications, B. Manual Rates, please explain "Physicians and non Physician Health Care Providers up to 30%".

7. In Section III under IV. Classifications, F. Physician Teaching Specialists, paragraph 1. a. references 7E on page 20 - it should be page 19.

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10. We don't understand the outlining order of the manual starting at page 14.

11. On page 17, under Territory Definitions, does Medicus only write in the counties listed? There is no reference to "remainder of the State" for any counties not listed. Winnebago County is misspelled.

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    a. 30% - is this a decrease, credit or debit?
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    d. 30% - is this a decrease, credit or debit?
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15. On page 21 under c., what is the amount of the discount (decrease, credit or debit)?

16. Pursuant to 50 Ill. Adm. Code 929, new insurers are required to file a statement indicating whether the company will report its medical liability statistics to a statistical agent (and if so, which one) or it the company has its own plan for the gathering of medical liability statistics. The Director, at any time, may request a copy of the company's statistical plan or request the company to provide written verification of membership and reporting status from the company's statistical agency.

17. All rate/rule filings must be accompanied by a statement indicating that the company, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

We request receipt of your response by March 22, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Steve Kinion [skinion@601w.com]
Sent: Friday, February 16, 2007 2:48 PM
To: Neuman, Gayle
Subject: Re: Medicus Medical Malpractice Filing
Attachments: Filing Authorization Letter Medicus IC and Zack Stamp, Ltd.pdf

Gayle

Thanks again for your assistance. Attached is the authorization letter.

Steve

----- Original Message -----

> **From:** Neuman, Gayle
> **To:** skinion@601w.com
> **Sent:** Friday, February 16, 2007 8:02 AM
> **Subject:** Medicus Medical Malpractice Filing
>
> Mr. Kinion,
>
> The filing received on February 15, 2007 did not include a letter of authorization from Medicus Insurance Company wherein they indicate Zack Stamp, Ltd. is authorized to submit such filing(s) on their behalf.
>
> You may forward such documentation to me by e-mail.
>
> Gayle Neuman
> Property & Casualty Compliance, Division of Insurance
> Illinois Department of Financial & Professional Regulation
> (217) 524-6497
>
> Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
> Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.
>
>

MEDICUS™
INSURANCE COMPANY

February 16, 2007

Ms. Gayle Neuman
Division of Insurance
Illinois Department of Financial and Professional Regulation
320 W. Washington Street
Springfield, IL 62767-0001

Re: Medicus Insurance Company
Submission of Rates, Rules, and Forms - Medical Malpractice Coverage

Dear Ms. Neuman:

The purpose of this letter is to authorize the law firm of Zack Stamp, Ltd. to submit rate, rule, and forms filings on behalf of this company. Thank you for your consideration and if you have any questions or comments, please call 512-879-5103.

Sincerely,

Bruce Arnold
Vice President, Underwriting

8500 Shoal Creek Blvd., Building 3, Suite 200, Austin, TX 78757 USA
T 512.467.2800 WWW.MEDICUSINSURANCE.COM F 877.686.0558

Comparison of ISMIE vs Medicus Insurance Company
Illinois Medical Malpractice Insurance Rates
January 2007

Territory I
Cook, Madison, St. Clair, and Will Counties

Territory II
Kane and McHenry Counties

Territory III
Bond, Clinton, Franklin, Hamilton, Jefferson, Washington, Williamson, & Rest of Illinois

Territory IV
DuPage, Kankakee, Macon, and Winnebago

Territory V
Lake and Vermillion Counties

Territory VI
Champaign, Bureau, Cole, Dekalb, Effingham, Lasalle, Ogle, Randolph, and Sangamon Counties

Territory VII
Jackson County

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory I		Territory II		Territory III		Territory IV	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Allergy	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Anesthesiology	$41,268	$37,141	$35,348	$31,813	$21,488	$19,339	$31,388	$28,249
Anesthesiology-Pain Management	$41,268	$37,141	$35,348	$31,813	$21,488	$19,339	$31,388	$28,249
Cardiovascular Disease-No Surgery	$34,088	$30,679	$29,228	$26,305	$17,888	$16,099	$25,988	$23,389
Cardiovascular Disease-Minor Surgery	$59,288	$53,359	$50,648	$45,583	$30,488	$27,439	$44,888	$40,399
Dermatology-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Dermatology-Minor Surgery	$48,106	$43,295	$41,045	$36,941	$24,572	$22,115	$36,337	$32,703
Diabetes-No Surgery	$32,288	$29,059	$27,700	$24,930	$16,988	$15,289	$24,640	$22,176
Emergency Medicine-No Major Surgery	$59,288	$53,359	$50,648	$45,583	$30,488	$27,439	$44,888	$40,399
Endocrinology-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Family/General Practitioners-No Surgery	$32,288	$29,059	$27,700	$24,930	$16,988	$15,289	$24,640	$22,176
Family/General Practitioners-Minor Surgery	$50,288	$45,259	$42,996	$38,696	$25,988	$23,389	$50,288	$45,259
Family/General Practitioners-Minor Surgery--0-24 deliv	$50,288	$45,259	$42,996	$38,696	$25,988	$23,389	$50,288	$45,259
Forensic or Legal Medicine	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Gastroenterology-No Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
Gastroenterology-Minor Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
General Preventive Medicine-No Surgery	$17,871	$16,084	$27,700	$24,930	$16,988	$15,289	$13,652	$12,287
Geriaterics-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Gynecology-No Surgery	$37,688	$33,919	$32,288	$29,059	$19,688	$17,719	$28,688	$25,819
Gynecology-Minor Surgery	$59,288	$53,359	$50,648	$45,583	$30,488	$27,439	$44,888	$40,399
Hematology-No Surgery +A63	$32,288	$29,059	$27,700	$24,930	$16,988	$15,289	$24,640	$22,176
Infectious Diseases-No Surgery	$34,088	$30,679	$29,228	$26,305	$17,888	$16,099	$25,988	$23,389
Internal Medicine-No Surgery	$37,688	$33,919	$32,288	$29,059	$19,688	$17,719	$28,688	$25,819
Internal Medicine-Minor Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
Laryngology-No Surgery	$17,871	$16,084	$15,338	$13,804	$9,433	$8,490	$13,652	$12,287
Laryngology-Minor Surgery	$47,812	$43,031	$40,794	$36,715	$24,423	$21,981	$36,116	$32,504
Neoplastic Diseases-No Surgery	$34,727	$31,254	$29,670	$26,703	$17,879	$16,091	$26,303	$23,673
Nephrology-No Surgery	$34,088	$30,679	$29,228	$26,305	$17,888	$16,099	$25,988	$23,389
Nephrology-Minor Surgery	$41,288	$37,159	$35,348	$31,813	$21,488	$19,339	$31,388	$28,249
Neurology-No Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
Neurology-Minor Surgery	$46,688	$42,019	$39,936	$35,942	$27,788	$25,009	$35,436	$31,892

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory I		Territory II		Territory III		Territory IV	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Nuclear Medicine	$32,288	$29,059	$27,700	$24,930	$16,988	$15,289	$24,640	$22,176
Occupational Medicine	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Oncology-No Surgery	$32,288	$29,059	$27,700	$24,930	$16,988	$15,289	$24,640	$22,176
Ophthalmology-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Otology-No Surgery	$17,871	$16,084	$15,338	$13,804	$9,433	$8,490	$13,652	$12,287
Otology-Minor Surgery	$47,812	$43,031	$40,794	$36,715	$24,423	$21,981	$36,116	$32,504
Otorhinolaryngology-No Surgery	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Otorhinolaryngology-Minor Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
Pathology-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Pediatrics-No Surgery	$25,088	$22,579	$21,580	$19,422	$13,388	$12,049	$19,240	$17,316
Pediatrics-Minor Surgery	$46,688	$42,019	$39,936	$35,942	$24,188	$21,769	$35,436	$31,892
Physiatry or Physical Medicine and Rehabilitation	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Physicians- Not otherwise classified-No Surgery	$30,952	$27,857	$26,468	$23,821	$16,004	$14,404	$23,476	$21,128
Physicians- Not otherwise classified-Minor Surgery	$48,888	$43,999	$41,712	$37,541	$24,972	$22,475	$36,928	$33,235
Psychiatry	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Public Health	$16,088	$14,479	$13,928	$12,535	$8,888	$7,999	$12,488	$11,239
Pulmonary Diseases-No Surgery	$41,288	$37,159	$35,348	$31,813	$21,488	$19,339	$31,388	$28,249
Radiology-Diagnostic-No Surgery	$41,288	$37,159	$35,348	$31,813	$21,488	$19,339	$31,388	$28,249
Radiology-Diagnostic-Minor Surgery	$65,354	$58,819	$50,648	$45,583	$24,188	$21,769	$44,888	$40,399
Radiology-Therapeutic	$47,910	$43,119	$40,878	$36,790	$24,473	$22,026	$36,189	$32,570
Rheumatology-No Surgery	$21,488	$19,339	$18,520	$16,668	$11,588	$10,429	$16,540	$14,886
Rhinology-No Surgery	$17,871	$16,084	$15,338	$13,804	$9,433	$8,490	$13,652	$12,287
Rhinology-Minor Surgery	$47,812	$43,031	$40,794	$36,715	$24,423	$21,981	$36,116	$32,504
Surgery-Cardiac	$131,284	$118,156	$111,844	$100,660	$66,488	$59,839	$98,888	$88,999
Sugery-Cardiovascular Disease	$131,284	$118,156	$111,844	$100,660	$66,488	$59,839	$98,999	$89,099
Surgery-Colon and Rectal	$59,288	$53,359	$50,648	$45,583	$30,488	$27,439	$44,888	$40,399
Surgery-Emergency Medicine	$66,488	$59,839	$56,768	$51,091	$34,088	$30,679	$50,288	$45,259
Surgery-Family/General Practice	$65,354	$58,819	$56,768	$51,091	$34,088	$30,679	$50,288	$45,259
Surgery-General-Not Otherwise Classified	$98,888	$88,999	$84,308	$75,877	$50,288	$45,259	$74,588	$67,129
Surgery-Gynecology	$66,488	$59,839	$56,768	$51,091	$34,088	$30,679	$50,288	$45,259
Surgery-Hand	$66,488	$59,839	$56,768	$51,091	$34,088	$30,679	$50,288	$45,259
Surgery-Head and Neck	$66,488	$59,839	$56,768	$51,091	$34,088	$30,679	$50,288	$45,259

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory I		Territory II		Territory III		Territory IV	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Surgery-Neonatology or Pediatrics	$102,488	$92,239	$87,368	$78,631	$52,088	$46,879	$77,288	$69,559
Surgery-Neurology	$228,484	$205,636	$194,464	$175,018	$115,084	$103,576	$171,784	$154,606
Surgery-Obstetrics	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
Surgery-Obstetrics-Gynecology	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
Surgery ObstetricsGynecology-0 to 49 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-50 to 69 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-70 to 89 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-90 to 109 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-110 to 129 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-130 to 149 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-150 to 169 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-170 to 189 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-190 to 209 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-210 to 229 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-230 to 249 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-250 to 269 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-270 to 289 deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
-290 or more deliveries	$138,484	$124,636	$117,964	$106,168	$70,088	$63,079	$104,284	$93,856
Surgery-Ophthalmology	$32,288	$29,059	$27,700	$24,930	$11,588	$10,429	$16,540	$14,886
Surgery-Orthopedic	$149,284	$134,356	$127,144	$114,430	$75,488	$67,939	$112,384	$101,146
Surgery-Orthopedic-without procedures on the back	$113,284	$101,956	$96,548	$86,893	$57,488	$51,739	$85,388	$76,849
Surgery-Otorhinolaryngology	$59,288	$53,359	$50,648	$45,583	$30,488	$27,439	$44,888	$40,399
Surgery-Plastic-Not Otherwise Classified	$102,488	$92,239	$87,368	$78,631	$52,088	$46,879	$77,288	$69,559
Surgery-Plastic-Otorhinolaryngology	$102,488	$92,239	$87,368	$78,631	$52,088	$46,879	$77,288	$69,559
Surgery-Thoracic	$131,284	$118,156	$111,844	$100,660	$66,488	$59,839	$98,888	$88,999
Surgery-Urological	$53,888	$48,499	$46,056	$41,450	$27,788	$25,009	$35,436	$31,892
Surgery-Vascular	$131,284	$118,156	$111,844	$100,660	$66,488	$59,839	$98,888	$88,999

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory V		Territory VI		Territory VII	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate
Allergy	$14,648	$13,183	$11,768	$10,591	$16,088	$14,479
Anesthesiology	$37,328	$33,595	$29,408	$26,467	$41,268	$37,141
Anesthesiology-Pain Management	$37,328	$33,595	$29,408	$26,467	$41,268	$37,141
Cardiovascular Disease-No Surgery	$30,848	$27,763	$24,368	$21,931	$34,088	$30,679
Cardiovascular Disease-Minor Surgery	$53,528	$48,175	$42,008	$37,807	$59,288	$53,359
Dermatology-No Surgery	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Dermatology-Minor Surgery	$43,398	$39,058	$33,983	$30,585	$48,106	$43,295
Diabetes-No Surgery	$29,228	$26,305	$23,108	$20,797	$32,288	$29,059
Emergency Medicine-No Major Surgery	$53,528	$48,175	$42,008	$37,807	$59,288	$53,359
Endocrinology-No Surgery	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Family/General Practitioners-No Surgery	$29,228	$26,305	$23,108	$20,797	$32,288	$29,059
Family/General Practitioners-Minor Surgery	$45,428	$40,885	$35,708	$32,137	$50,288	$45,259
Family/General Practitioners-Minor Surgery--0-24 deliv	$45,428	$40,885	$35,708	$32,137	$50,288	$45,259
Forensic or Legal Medicine	$14,648	$13,183	$11,768	$10,591	$16,088	$14,479
Gastroenterology-No Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
Gastroenterology-Minor Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
General Preventive Medicine-No Surgery	$29,228	$26,305	$23,108	$20,797	$17,871	$16,084
Geriaterics-No Surgery	$19,508	$17,557	$23,108	$20,797	$21,488	$19,339
Gynecology-No Surgery	$34,088	$30,679	$26,888	$24,199	$37,688	$33,919
Gynecology-Minor Surgery	$53,528	$48,175	$47,048	$42,343	$59,288	$53,359
Hematology-No Surgery +A63	$29,228	$26,305	$23,108	$20,797	$32,288	$29,059
Infectious Diseases-No Surgery	$30,848	$27,763	$24,368	$21,931	$34,088	$30,679
Internal Medicine-No Surgery	$34,088	$30,679	$26,888	$24,199	$37,688	$33,919
Internal Medicine-Minor Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
Laryngology-No Surgery	$16,185	$14,567	$12,809	$11,528	$17,871	$16,084
Laryngology-Minor Surgery	$43,134	$38,821	$33,776	$30,398	$47,812	$43,031
Neoplastic Diseases-No Surgery	$31,356	$28,220	$24,618	$22,156	$34,727	$31,254
Nephrology-No Surgery	$30,848	$27,763	$24,368	$21,931	$34,088	$30,679
Nephrology-Minor Surgery	$37,328	$33,595	$29,408	$26,467	$41,288	$37,159
Neurology-No Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
Neurology-Minor Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory V		Territory VI		Territory VII	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate
Nuclear Medicine	$29,228	$26,305	$23,108	$20,797	$32,288	$29,059
Occupational Medicine	$14,648	$13,183	$11,768	$10,591	$16,088	$14,479
Oncology-No Surgery	$29,228	$26,305	$23,108	$20,797	$32,288	$29,059
Ophthalmology-No Surgery	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Otology-No Surgery	$16,185	$14,567	$12,809	$11,528	$17,871	$16,084
Otology-Minor Surgery	$43,134	$38,821	$33,776	$30,398	$47,812	$43,031
Otorhinolaryngology-No Surgery	$14,648	$13,183	$11,768	$10,591	$16,088	$14,479
Otorhinolaryngology-Minor Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
Pathology-No Surgery	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Pediatrics-No Surgery	$22,748	$20,473	$18,068	$16,261	$25,088	$22,579
Pediatrics-Minor Surgery	$42,188	$37,969	$33,188	$29,869	$46,688	$42,019
Physiatry or Physical Medicine and Rehabilitation	$14,648	$13,183	$11,768	$10,591	$16,088	$14,479
Physicians- Not otherwise classified-No Surgery	$27,960	$25,164	$21,980	$19,782	$30,952	$27,857
Physicians- Not otherwise classified-Minor Surgery	$44,104	$39,694	$34,536	$31,082	$48,888	$43,999
Psychiatry	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Public Health	$16,648	$14,983	$11,768	$10,591	$16,088	$14,479
Pulmonary Diseases-No Surgery	$37,328	$33,595	$29,408	$26,467	$41,288	$37,159
Radiology-Diagnostic-No Surgery	$37,328	$33,595	$29,408	$26,467	$41,288	$37,159
Radiology-Diagnostic-Minor Surgery	$65,354	$58,819	$42,008	$37,807	$65,354	$58,819
Radiology-Therapeutic	$43,222	$38,900	$33,845	$30,461	$47,910	$43,119
Rheumatology-No Surgery	$19,508	$17,557	$15,548	$13,993	$21,488	$19,339
Rhinology-No Surgery	$16,185	$14,567	$12,809	$11,528	$17,871	$16,084
Rhinology-Minor Surgery	$43,134	$38,821	$33,776	$30,398	$47,812	$43,031
Surgery-Cardiac	$118,324	$106,492	$92,408	$83,167	$131,284	$118,156
Sugery-Cardiovascular Disease	$118,324	$106,492	$92,408	$83,167	$143,261	$128,935
Surgery-Colon and Rectal	$53,528	$48,175	$42,008	$37,807	$59,288	$53,359
Surgery-Emergency Medicine	$60,008	$54,007	$47,048	$42,343	$66,488	$59,839
Surgery-Family/General Practice	$60,008	$54,007	$47,048	$42,343	$65,354	$58,819
Surgery-General-Not Otherwise Classified	$89,168	$80,251	$69,728	$62,755	$98,888	$88,999
Surgery-Gynecology	$60,008	$54,007	$47,048	$42,343	$66,488	$59,839
Surgery-Hand	$60,008	$54,007	$47,048	$42,343	$66,488	$59,839
Surgery-Head and Neck	$60,008	$54,007	$47,048	$42,343	$66,488	$59,839

Comparison of ISMIE vs Medicus Insurance Company

Illinois Medical Malpractice Insurance Rates -

January 2007 **$1,000,000/3,000,000 Mature Rates**

Note: Medicus rates are 90% of ISMIE rates.

	Territory V		Territory VI		Territory VII	
	ISMIE	MEDICUS	ISMIE	MEDICUS	ISMIE	MEDICUS
Classification	Rate	Rate	Rate	Rate	Rate	Rate
Surgery-Neonatology or Pediatrics	$92,408	$83,167	$72,248	$65,023	$102,488	$92,239
Surgery-Neurology	$205,804	$185,224	$160,444	$144,400	$244,473	$220,026
Surgery-Obstetrics	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
Surgery-Obstetrics-Gynecology	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
Surgery ObstetricsGynecology-0 to 49 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-50 to 69 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-70 to 89 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-90 to 109 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-110 to 129 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-130 to 149 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-150 to 169 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-170 to 189 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-190 to 209 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-210 to 229 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-230 to 249 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-250 to 269 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-270 to 289 deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
-290 or more deliveries	$124,804	$112,324	$97,448	$87,703	$138,484	$124,636
Surgery-Ophthalmology	$29,228	$26,305	$15,548	$13,993	$32,288	$29,059
Surgery-Orthopedic	$134,524	$121,072	$105,004	$94,504	$149,284	$134,356
Surgery-Orthopedic-without procedures on the back	$102,128	$91,915	$79,808	$71,827	$113,284	$101,956
Surgery-Otorhinolaryngology	$53,528	$48,175	$42,008	$37,807	$59,288	$53,359
Surgery-Plastic-Not Otherwise Classified	$92,408	$83,167	$72,248	$65,023	$102,488	$92,239
Surgery-Plastic-Otorhinolaryngology	$92,408	$83,167	$72,248	$65,023	$102,488	$92,239
Surgery-Thoracic	$118,324	$106,492	$92,408	$83,167	$131,284	$118,156
Surgery-Urological	$48,668	$43,801	$38,228	$34,405	$53,888	$48,499
Surgery-Vascular	$118,324	$106,492	$92,408	$83,167	$131,284	$118,156

Illinois Rates

Cook, Madison, St. Clair, and Will Counties

Classification	Rate
Allergy	$14,479
Anesthesiology	$37,141
Anesthesiology-Pain Management	$37,141
Cardiovascular Disease-No Surgery	$30,679
Cardiovascular Disease-Minor Surgery	$53,359
Dermatology-No Surgery	$19,339
Dermatology-Minor Surgery	$43,295
Diabetes-No Surgery	$29,059
Emergency Medicine-No Major Surgery	$53,359
Endocrinology-No Surgery	$19,339
Family/General Practitioners-No Surgery	$29,059
Family/General Practitioners-Minor Surgery	$45,259
Family/General Practitioners-Minor Surgery--0-24 deliveries	$45,259
Forensic or Legal Medicine	$14,479
Gastroenterology-No Surgery	$42,019
Gastroenterology-Minor Surgery	$42,019
General Preventive Medicine-No Surgery	$16,084
Geriaterics-No Surgery	$19,339
Gynecology-No Surgery	$33,919
Gynecology-Minor Surgery	$53,359
Hematology-No Surgery +A63	$29,059
Infectious Diseases-No Surgery	$30,679
Internal Medicine-No Surgery	$33,919
Internal Medicine-Minor Surgery	$42,019
Laryngology-No Surgery	$16,084
Laryngology-Minor Surgery	$43,031
Neoplastic Diseases-No Surgery	$31,254
Nephrology-No Surgery	$30,679
Nephrology-Minor Surgery	$37,159
Neurology-No Surgery	$42,019
Neurology-Minor Surgery	$42,019
Nuclear Medicine	$29,059
Occupational Medicine	$14,479
Oncology-No Surgery	$29,059
Ophthalmology-No Surgery	$19,339
Otology-No Surgery	$16,084
Otology-Minor Surgery	$43,031
Otorhinolaryngology-No Surgery	$14,479
Otorhinolaryngology-Minor Surgery	$42,019
Pathology-No Surgery	$19,339
Pediatrics-No Surgery	$22,579
Pediatrics-Minor Surgery	$42,019
Physiatry or Physical Medicine and Rehabilitation	$14,479
Physicians- Not otherwise classified-No Surgery	$27,857
Physicians- Not otherwise classified-Minor Surgery	$43,999

Psychiatry	$19,339
Public Health	$14,479
Pulmonary Diseases-No Surgery	$37,159
Radiology-Diagnostic-No Surgery	$37,159
Radiology-Diagnostic-Minor Surgery	$58,819
Radiology-Therapeutic	$43,119
Rheumatology-No Surgery	$19,339
Rhinology-No Surgery	$16,084
Rhinology-Minor Surgery	$43,031
Surgery-Cardiac	$118,156
Sugery-Cardiovascular Disease	$118,156
Surgery-Colon and Rectal	$53,359
Surgery-Emergency Medicine	$59,839
Surgery-Family/General Practice	$58,819
Surgery-General-Not Otherwise Classified	$88,999
Surgery-Gynecology	$59,839
Surgery-Hand	$59,839
Surgery-Head and Neck	$59,839
Surgery-Neonatology or Pediatrics	$92,239
Surgery-Neurology	$205,636
Surgery-Obstetrics	$124,636
Surgery-Obstetrics-Gynecology	$124,636
Surgery ObstetricsGynecology-0 to 49 deliveries	$124,636
-50 to 69 deliveries	$124,636
-70 to 89 deliveries	$124,636
-90 to 109 deliveries	$124,636
-110 to 129 deliveries	$124,636
-130 to 149 deliveries	$124,636
-150 to 169 deliveries	$124,636
-170 to 189 deliveries	$124,636
-190 to 209 deliveries	$124,636
-210 to 229 deliveries	$124,636
-230 to 249 deliveries	$124,636
-250 to 269 deliveries	$124,636
-270 to 289 deliveries	$124,636
-290 or more deliveries	$124,636
Surgery-Ophthalmology	$29,059
Surgery-Orthopedic	$134,356
Surgery-Orthopedic-without procedures on the back	$101,956
Surgery-Otorhinolaryngology	$53,359
Surgery-Plastic-Not Otherwise Classified	$92,239
Surgery-Plastic-Otorhinolaryngology	$92,239
Surgery-Thoracic	$118,156
Surgery-Urological	$48,499
Surgery-Vascular	$118,156

Illinois Rates
Kane and McHenry Counties

Classification	Rate
Allergy	$12,535
Anesthesiology	$31,813
Anesthesiology-Pain Management	$31,813
Cardiovascular Disease-No Surgery	$26,305
Cardiovascular Disease-Minor Surgery	$45,583
Dermatology-No Surgery	$16,668
Dermatology-Minor Surgery	$36,941
Diabetes-No Surgery	$24,930
Emergency Medicine-No Major Surgery	$45,583
Endocrinology-No Surgery	$16,668
Family/General Practitioners-No Surgery	$24,930
Family/General Practitioners-Minor Surgery	$38,696
Family/General Practitioners-Minor Surgery--0-24 deliveries	$38,696
Forensic or Legal Medicine	$12,535
Gastroenterology-No Surgery	$35,942
Gastroenterology-Minor Surgery	$35,942
General Preventive Medicine-No Surgery	$24,930
Geriatrics-No Surgery	$16,668
Gynecology-No Surgery	$29,059
Gynecology-Minor Surgery	$45,583
Hematology-No Surgery +A63	$24,930
Infectious Diseases-No Surgery	$26,305
Internal Medicine-No Surgery	$29,059
Internal Medicine-Minor Surgery	$35,942
Laryngology-No Surgery	$13,804
Laryngology-Minor Surgery	$36,715
Neoplastic Diseases-No Surgery	$26,703
Nephrology-No Surgery	$26,305
Nephrology-Minor Surgery	$31,813
Neurology-No Surgery	$35,942
Neurology-Minor Surgery	$35,942
Nuclear Medicine	$24,930
Occupational Medicine	$12,535
Oncology-No Surgery	$24,930
Ophthalmology-No Surgery	$16,668
Otology-No Surgery	$13,804
Otology-Minor Surgery	$36,715
Otorhinolaryngology-No Surgery	$12,535
Otorhinolaryngology-Minor Surgery	$35,942
Pathology-No Surgery	$16,668
Pediatrics-No Surgery	$19,422
Pediatrics-Minor Surgery	$35,942
Physiatry or Physical Medicine and Rehabilitation	$12,535
Physicians- Not otherwise classified-No Surgery	$23,821
Physicians- Not otherwise classified-Minor Surgery	$37,541

Psychiatry	$16,668
Public Health	$12,535
Pulmonary Diseases-No Surgery	$31,813
Radiology-Diagnostic-No Surgery	$31,813
Radiology-Diagnostic-Minor Surgery	$45,583
Radiology-Therapeutic	$36,790
Rheumatology-No Surgery	$16,668
Rhinology-No Surgery	$13,804
Rhinology-Minor Surgery	$36,715
Surgery-Cardiac	$100,660
Surgery-Cardiovascular Disease	$100,660
Surgery-Colon and Rectal	$45,583
Surgery-Emergency Medicine	$51,091
Surgery-Family/General Practice	$51,091
Surgery-General-Not Otherwise Classified	$75,877
Surgery-Gynecology	$51,091
Surgery-Hand	$51,091
Surgery-Head and Neck	$51,091
Surgery-Neonatology or Pediatrics	$78,631
Surgery-Neurology	$175,018
Surgery-Obstetrics	$106,168
Surgery-Obstetrics-Gynecology	$106,168
Surgery ObstetricsGynecology-0 to 49 deliveries	$106,168
-50 to 69 deliveries	$106,168
-70 to 89 deliveries	$106,168
-90 to 109 deliveries	$106,168
-110 to 129 deliveries	$106,168
-130 to 149 deliveries	$106,168
-150 to 169 deliveries	$106,168
-170 to 189 deliveries	$106,168
-190 to 209 deliveries	$106,168
-210 to 229 deliveries	$106,168
-230 to 249 deliveries	$106,168
-250 to 269 deliveries	$106,168
-270 to 289 deliveries	$106,168
-290 or more deliveries	$106,168
Surgery-Ophthalmology	$24,930
Surgery-Orthopedic	$114,430
Surgery-Orthopedic-without procedures on the back	$86,893
Surgery-Otorhinolaryngology	$45,583
Surgery-Plastic-Not Otherwise Classified	$78,631
Surgery-Plastic-Otorhinolaryngology	$78,631
Surgery-Thoracic	$100,660
Surgery-Urological	$41,450
Surgery-Vascular	$100,660

Illinois Rates

Bond, Clinton, Franklin, Hamilton, Jefferson, Washington, Williamson, & Rest of Illinois

Classification	Rate
Allergy	$7,999
Anesthesiology	$19,339
Anesthesiology-Pain Management	$19,339
Cardiovascular Disease-No Surgery	$16,099
Cardiovascular Disease-Minor Surgery	$27,439
Dermatology-No Surgery	$10,429
Dermatology-Minor Surgery	$22,115
Diabetes-No Surgery	$15,289
Emergency Medicine-No Major Surgery	$27,439
Endocrinology-No Surgery	$10,429
Family/General Practitioners-No Surgery	$15,289
Family/General Practitioners-Minor Surgery	$23,389
Family/General Practitioners-Minor Surgery--0-24 deliveries	$23,389
Forensic or Legal Medicine	$7,999
Gastroenterology-No Surgery	$21,769
Gastroenterology-Minor Surgery	$21,769
General Preventive Medicine-No Surgery	$15,289
Geriaterics-No Surgery	$10,429
Gynecology-No Surgery	$17,719
Gynecology-Minor Surgery	$27,439
Hematology-No Surgery +A63	$15,289
Infectious Diseases-No Surgery	$16,099
Internal Medicine-No Surgery	$17,719
Internal Medicine-Minor Surgery	$21,769
Laryngology-No Surgery	$8,490
Laryngology-Minor Surgery	$21,981
Neoplastic Diseases-No Surgery	$16,091
Nephrology-No Surgery	$16,099
Nephrology-Minor Surgery	$19,339
Neurology-No Surgery	$21,769
Neurology-Minor Surgery	$25,009
Nuclear Medicine	$15,289
Occupational Medicine	$7,999
Oncology-No Surgery	$15,289
Ophthalmology-No Surgery	$10,429
Otology-No Surgery	$8,490
Otology-Minor Surgery	$21,981
Otorhinolaryngology-No Surgery	$7,999
Otorhinolaryngology-Minor Surgery	$21,769
Pathology-No Surgery	$10,429
Pediatrics-No Surgery	$12,049
Pediatrics-Minor Surgery	$21,769
Physiatry or Physical Medicine and Rehabilitation	$7,999
Physicians- Not otherwise classified-No Surgery	$14,404

Physicians- Not otherwise classified-Minor Surgery	$22,475
Psychiatry	$10,429
Public Health	$7,999
Pulmonary Diseases-No Surgery	$19,339
Radiology-Diagnostic-No Surgery	$19,339
Radiology-Diagnostic-Minor Surgery	$21,769
Radiology-Therapeutic	$22,026
Rheumatology-No Surgery	$10,429
Rhinology-No Surgery	$8,490
Rhinology-Minor Surgery	$21,981
Surgery-Cardiac	$59,839
Sugery-Cardiovascular Disease	$59,839
Surgery-Colon and Rectal	$27,439
Surgery-Emergency Medicine	$30,679
Surgery-Family/General Practice	$30,679
Surgery-General-Not Otherwise Classified	$45,259
Surgery-Gynecology	$30,679
Surgery-Hand	$30,679
Surgery-Head and Neck	$30,679
Surgery-Neonatology or Pediatrics	$46,879
Surgery-Neurology	$103,576
Surgery-Obstetrics	$63,079
Surgery-Obstetrics-Gynecology	$63,079
Surgery ObstetricsGynecology-0 to 49 deliveries	$63,079
-50 to 69 deliveries	$63,079
-70 to 89 deliveries	$63,079
-90 to 109 deliveries	$63,079
-110 to 129 deliveries	$63,079
-130 to 149 deliveries	$63,079
-150 to 169 deliveries	$63,079
-170 to 189 deliveries	$63,079
-190 to 209 deliveries	$63,079
-210 to 229 deliveries	$63,079
-230 to 249 deliveries	$63,079
-250 to 269 deliveries	$63,079
-270 to 289 deliveries	$63,079
-290 or more deliveries	$63,079
Surgery-Ophthalmology	$10,429
Surgery-Orthopedic	$67,939
Surgery-Orthopedic-without procedures on the back	$51,739
Surgery-Otorhinolaryngology	$27,439
Surgery-Plastic-Not Otherwise Classified	$46,879
Surgery-Plastic-Otorhinolaryngology	$46,879
Surgery-Thoracic	$59,839
Surgery-Urological	$25,009
Surgery-Vascular	$59,839

Illinois Rates

DuPage, Kankakee, Macon, and Winnebago

Classification	Rate
Allergy	$11,239
Anesthesiology	$28,249
Anesthesiology-Pain Management	$28,249
Cardiovascular Disease-No Surgery	$23,389
Cardiovascular Disease-Minor Surgery	$40,399
Dermatology-No Surgery	$14,886
Dermatology-Minor Surgery	$32,703
Diabetes-No Surgery	$22,176
Emergency Medicine-No Major Surgery	$40,399
Endocrinology-No Surgery	$14,886
Family/General Practitioners-No Surgery	$22,176
Family/General Practitioners-Minor Surgery	$45,259
Family/General Practitioners-Minor Surgery--0-24 deliveries	$45,259
Forensic or Legal Medicine	$11,239
Gastroenterology-No Surgery	$31,892
Gastroenterology-Minor Surgery	$31,892
General Preventive Medicine-No Surgery	$12,287
Geriaterics-No Surgery	$14,886
Gynecology-No Surgery	$25,819
Gynecology-Minor Surgery	$40,399
Hematology-No Surgery +A63	$22,176
Infectious Diseases-No Surgery	$23,389
Internal Medicine-No Surgery	$25,819
Internal Medicine-Minor Surgery	$31,892
Laryngology-No Surgery	$12,287
Laryngology-Minor Surgery	$32,504
Neoplastic Diseases-No Surgery	$23,673
Nephrology-No Surgery	$23,389
Nephrology-Minor Surgery	$28,249
Neurology-No Surgery	$31,892
Neurology-Minor Surgery	$31,892
Nuclear Medicine	$22,176
Occupational Medicine	$11,239
Oncology-No Surgery	$22,176
Ophthalmology-No Surgery	$14,886
Otology-No Surgery	$12,287
Otology-Minor Surgery	$32,504
Otorhinolaryngology-No Surgery	$11,239
Otorhinolaryngology-Minor Surgery	$31,892
Pathology-No Surgery	$14,886
Pediatrics-No Surgery	$17,316
Pediatrics-Minor Surgery	$31,892
Physiatry or Physical Medicine and Rehabilitation	$11,239
Physicians- Not otherwise classified-No Surgery	$21,128

Physicians- Not otherwise classified-Minor Surgery	$33,235
Psychiatry	$14,886
Public Health	$11,239
Pulmonary Diseases-No Surgery	$28,249
Radiology-Diagnostic-No Surgery	$28,249
Radiology-Diagnostic-Minor Surgery	$40,399
Radiology-Therapeutic	$32,570
Rheumatology-No Surgery	$14,886
Rhinology-No Surgery	$12,287
Rhinology-Minor Surgery	$32,504
Surgery-Cardiac	$88,999
Sugery-Cardiovascular Disease	$89,099
Surgery-Colon and Rectal	$40,399
Surgery-Emergency Medicine	$45,259
Surgery-Family/General Practice	$45,259
Surgery-General-Not Otherwise Classified	$67,129
Surgery-Gynecology	$45,259
Surgery-Hand	$45,259
Surgery-Head and Neck	$45,259
Surgery-Neonatology or Pediatrics	$69,559
Surgery-Neurology	$154,606
Surgery-Obstetrics	$93,856
Surgery-Obstetrics-Gynecology	$93,856
Surgery ObstetricsGynecology-0 to 49 deliveries	$93,856
-50 to 69 deliveries	$93,856
-70 to 89 deliveries	$93,856
-90 to 109 deliveries	$93,856
-110 to 129 deliveries	$93,856
-130 to 149 deliveries	$93,856
-150 to 169 deliveries	$93,856
-170 to 189 deliveries	$93,856
-190 to 209 deliveries	$93,856
-210 to 229 deliveries	$93,856
-230 to 249 deliveries	$93,856
-250 to 269 deliveries	$93,856
-270 to 289 deliveries	$93,856
-290 or more deliveries	$93,856
Surgery-Ophthalmology	$14,886
Surgery-Orthopedic	$101,146
Surgery-Orthopedic-without procedures on the back	$76,849
Surgery-Otorhinolaryngology	$40,399
Surgery-Plastic-Not Otherwise Classified	$69,559
Surgery-Plastic-Otorhinolaryngology	$69,559
Surgery-Thoracic	$88,999
Surgery-Urological	$31,892
Surgery-Vascular	$88,999

Illinois Rates

Lake and Vermillion Counties

Classification	Rate
Allergy	$13,183
Anesthesiology	$33,595
Anesthesiology-Pain Management	$33,595
Cardiovascular Disease-No Surgery	$27,763
Cardiovascular Disease-Minor Surgery	$48,175
Dermatology-No Surgery	$17,557
Dermatology-Minor Surgery	$39,058
Diabetes-No Surgery	$26,305
Emergency Medicine-No Major Surgery	$48,175
Endocrinology-No Surgery	$17,557
Family/General Practitioners-No Surgery	$26,305
Family/General Practitioners-Minor Surgery	$40,885
Family/General Practitioners-Minor Surgery--0-24 deliveries	$40,885
Forensic or Legal Medicine	$13,183
Gastroenterology-No Surgery	$37,969
Gastroenterology-Minor Surgery	$37,969
General Preventive Medicine-No Surgery	$26,305
Geriaterics-No Surgery	$17,557
Gynecology-No Surgery	$30,679
Gynecology-Minor Surgery	$48,175
Hematology-No Surgery +A63	$26,305
Infectious Diseases-No Surgery	$27,763
Internal Medicine-No Surgery	$30,679
Internal Medicine-Minor Surgery	$37,969
Laryngology-No Surgery	$14,567
Laryngology-Minor Surgery	$38,821
Neoplastic Diseases-No Surgery	$28,220
Nephrology-No Surgery	$27,763
Nephrology-Minor Surgery	$33,595
Neurology-No Surgery	$37,969
Neurology-Minor Surgery	$37,969
Nuclear Medicine	$26,305
Occupational Medicine	$13,183
Oncology-No Surgery	$26,305
Ophthalmology-No Surgery	$17,557
Otology-No Surgery	$14,567
Otology-Minor Surgery	$38,821
Otorhinolaryngology-No Surgery	$13,183
Otorhinolaryngology-Minor Surgery	$37,969
Pathology-No Surgery	$17,557
Pediatrics-No Surgery	$20,473
Pediatrics-Minor Surgery	$37,969
Physiatry or Physical Medicine and Rehabilitation	$13,183
Physicians- Not otherwise classified-No Surgery	$25,164
Physicians- Not otherwise classified-Minor Surgery	$39,694

Psychiatry	$17,557
Public Health	$14,983
Pulmonary Diseases-No Surgery	$33,595
Radiology-Diagnostic-No Surgery	$33,595
Radiology-Diagnostic-Minor Surgery	$58,819
Radiology-Therapeutic	$38,900
Rheumatology-No Surgery	$17,557
Rhinology-No Surgery	$14,567
Rhinology-Minor Surgery	$38,821
Surgery-Cardiac	$106,492
Sugery-Cardiovascular Disease	$106,492
Surgery-Colon and Rectal	$48,175
Surgery-Emergency Medicine	$54,007
Surgery-Family/General Practice	$54,007
Surgery-General-Not Otherwise Classified	$80,251
Surgery-Gynecology	$54,007
Surgery-Hand	$54,007
Surgery-Head and Neck	$54,007
Surgery-Neonatology or Pediatrics	$83,167
Surgery-Neurology	$185,224
Surgery-Obstetrics	$112,324
Surgery-Obstetrics-Gynecology	$112,324
Surgery ObstetricsGynecology -0 to 49 deliveries	$112,324
-50 to 69 deliveries	$112,324
-70 to 89 deliveries	$112,324
-90 to 109 deliveries	$112,324
-110 to 129 deliveries	$112,324
-130 to 149 deliveries	$112,324
-150 to 169 deliveries	$112,324
-170 to 189 deliveries	$112,324
-190 to 209 deliveries	$112,324
-210 to 229 deliveries	$112,324
-230 to 249 deliveries	$112,324
-250 to 269 deliveries	$112,324
-270 to 289 deliveries	$112,324
-290 or more deliveries	$112,324
Surgery-Ophthalmology	$26,305
Surgery-Orthopedic	$121,072
Surgery-Orthopedic-without procedures on the back	$91,915
Surgery-Otorhinolaryngology	$48,175
Surgery-Plastic-Not Otherwise Classified	$83,167
Surgery-Plastic-Otorhinolaryngology	$83,167
Surgery-Thoracic	$106,492
Surgery-Urological	$43,801
Surgery-Vascular	$106,492

Illinois Rates

Champaign, Bureau, Cole, Dekalb, Effingham, Lasalle, Ogle, Randolph, and Sangamon Counties

Classification	Rate
Allergy	$10,591
Anesthesiology	$26,467
Anesthesiology-Pain Management	$26,467
Cardiovascular Disease-No Surgery	$21,931
Cardiovascular Disease-Minor Surgery	$37,807
Dermatology-No Surgery	$13,993
Dermatology-Minor Surgery	$30,585
Diabetes-No Surgery	$20,797
Emergency Medicine-No Major Surgery	$37,807
Endocrinology-No Surgery	$13,993
Family/General Practitioners-No Surgery	$20,797
Family/General Practitioners-Minor Surgery	$32,137
Family/General Practitioners-Minor Surgery--0-24 deliveries	$32,137
Forensic or Legal Medicine	$10,591
Gastroenterology-No Surgery	$29,869
Gastroenterology-Minor Surgery	$29,869
General Preventive Medicine-No Surgery	$20,797
Geriaterics-No Surgery	$20,797
Gynecology-No Surgery	$24,199
Gynecology-Minor Surgery	$42,343
Hematology-No Surgery +A63	$20,797
Infectious Diseases-No Surgery	$21,931
Internal Medicine-No Surgery	$24,199
Internal Medicine-Minor Surgery	$29,869
Laryngology-No Surgery	$11,528
Laryngology-Minor Surgery	$30,398
Neoplastic Diseases-No Surgery	$22,156
Nephrology-No Surgery	$21,931
Nephrology-Minor Surgery	$26,467
Neurology-No Surgery	$29,869
Neurology-Minor Surgery	$29,869
Nuclear Medicine	$20,797
Occupational Medicine	$10,591
Oncology-No Surgery	$20,797
Ophthalmology-No Surgery	$13,993
Otology-No Surgery	$11,528
Otology-Minor Surgery	$30,398
Otorhinolaryngology-No Surgery	$10,591
Otorhinolaryngology-Minor Surgery	$29,869
Pathology-No Surgery	$13,993
Pediatrics-No Surgery	$16,261
Pediatrics-Minor Surgery	$29,869
Physiatry or Physical Medicine and Rehabilitation	$10,591
Physicians- Not otherwise classified-No Surgery	$19,782

Physicians- Not otherwise classified-Minor Surgery	$31,082
Psychiatry	$13,993
Public Health	$10,591
Pulmonary Diseases-No Surgery	$26,467
Radiology-Diagnostic-No Surgery	$26,467
Radiology-Diagnostic-Minor Surgery	$37,807
Radiology-Therapeutic	$30,461
Rheumatology-No Surgery	$13,993
Rhinology-No Surgery	$11,528
Rhinology-Minor Surgery	$30,398
Surgery-Cardiac	$83,167
Sugery-Cardiovascular Disease	$83,167
Surgery-Colon and Rectal	$37,807
Surgery-Emergency Medicine	$42,343
Surgery-Family/General Practice	$42,343
Surgery-General-Not Otherwise Classified	$62,755
Surgery-Gynecology	$42,343
Surgery-Hand	$42,343
Surgery-Head and Neck	$42,343
Surgery-Neonatology or Pediatrics	$65,023
Surgery-Neurology	$144,400
Surgery-Obstetrics	$87,703
Surgery-Obstetrics-Gynecology	$87,703
Surgery ObstetricsGynecology-0 to 49 deliveries	$87,703
-50 to 69 deliveries	$87,703
-70 to 89 deliveries	$87,703
-90 to 109 deliveries	$87,703
-110 to 129 deliveries	$87,703
-130 to 149 deliveries	$87,703
-150 to 169 deliveries	$87,703
-170 to 189 deliveries	$87,703
-190 to 209 deliveries	$87,703
-210 to 229 deliveries	$87,703
-230 to 249 deliveries	$87,703
-250 to 269 deliveries	$87,703
-270 to 289 deliveries	$87,703
-290 or more deliveries	$87,703
Surgery-Ophthalmology	$13,993
Surgery-Orthopedic	$94,504
Surgery-Orthopedic-without procedures on the back	$71,827
Surgery-Otorhinolaryngology	$37,807
Surgery-Plastic-Not Otherwise Classified	$65,023
Surgery-Plastic-Otorhinolaryngology	$65,023
Surgery-Thoracic	$83,167
Surgery-Urological	$34,405
Surgery-Vascular	$83,167

Illinois Rates

Jackson County

Classification	Rate
Allergy	$14,479
Anesthesiology	$37,141
Anesthesiology-Pain Management	$37,141
Cardiovascular Disease-No Surgery	$30,679
Cardiovascular Disease-Minor Surgery	$53,359
Dermatology-No Surgery	$19,339
Dermatology-Minor Surgery	$43,295
Diabetes-No Surgery	$29,059
Emergency Medicine-No Major Surgery	$53,359
Endocrinology-No Surgery	$19,339
Family/General Practitioners-No Surgery	$29,059
Family/General Practitioners-Minor Surgery	$45,259
Family/General Practitioners-Minor Surgery--0-24 deliveries	$45,259
Forensic or Legal Medicine	$14,479
Gastroenterology-No Surgery	$42,019
Gastroenterology-Minor Surgery	$42,019
General Preventive Medicine-No Surgery	$16,084
Geriaterics-No Surgery	$19,339
Gynecology-No Surgery	$33,919
Gynecology-Minor Surgery	$53,359
Hematology-No Surgery +A63	$29,059
Infectious Diseases-No Surgery	$30,679
Internal Medicine-No Surgery	$33,919
Internal Medicine-Minor Surgery	$42,019
Laryngology-No Surgery	$16,084
Laryngology-Minor Surgery	$43,031
Neoplastic Diseases-No Surgery	$31,254
Nephrology-No Surgery	$30,679
Nephrology-Minor Surgery	$37,159
Neurology-No Surgery	$42,019
Neurology-Minor Surgery	$42,019
Nuclear Medicine	$29,059
Occupational Medicine	$14,479
Oncology-No Surgery	$29,059
Ophthalmology-No Surgery	$19,339
Otology-No Surgery	$16,084
Otology-Minor Surgery	$43,031
Otorhinolaryngology-No Surgery	$14,479
Otorhinolaryngology-Minor Surgery	$42,019
Pathology-No Surgery	$19,339
Pediatrics-No Surgery	$22,579
Pediatrics-Minor Surgery	$42,019
Physiatry or Physical Medicine and Rehabilitation	$14,479
Physicians- Not otherwise classified-No Surgery	$27,857
Physicians- Not otherwise classified-Minor Surgery	$43,999

Psychiatry	$19,339
Public Health	$14,479
Pulmonary Diseases-No Surgery	$37,159
Radiology-Diagnostic-No Surgery	$37,159
Radiology-Diagnostic-Minor Surgery	$58,819
Radiology-Therapeutic	$43,119
Rheumatology-No Surgery	$19,339
Rhinology-No Surgery	$16,084
Rhinology-Minor Surgery	$43,031
Surgery-Cardiac	$118,156
Sugery-Cardiovascular Disease	$128,935
Surgery-Colon and Rectal	$53,359
Surgery-Emergency Medicine	$59,839
Surgery-Family/General Practice	$58,819
Surgery-General-Not Otherwise Classified	$88,999
Surgery-Gynecology	$59,839
Surgery-Hand	$59,839
Surgery-Head and Neck	$59,839
Surgery-Neonatology or Pediatrics	$92,239
Surgery-Neurology	$220,026
Surgery-Obstetrics	$124,636
Surgery-Obstetrics-Gynecology	$124,636
Surgery ObstetricsGynecology-0 to 49 deliveries	$124,636
-50 to 69 deliveries	$124,636
-70 to 89 deliveries	$124,636
-90 to 109 deliveries	$124,636
-110 to 129 deliveries	$124,636
-130 to 149 deliveries	$124,636
-150 to 169 deliveries	$124,636
-170 to 189 deliveries	$124,636
-190 to 209 deliveries	$124,636
-210 to 229 deliveries	$124,636
-230 to 249 deliveries	$124,636
-250 to 269 deliveries	$124,636
-270 to 289 deliveries	$124,636
-290 or more deliveries	$124,636
Surgery-Ophthalmology	$29,059
Surgery-Orthopedic	$134,356
Surgery-Orthopedic-without procedures on the back	$101,956
Surgery-Otorhinolaryngology	$53,359
Surgery-Plastic-Not Otherwise Classified	$92,239
Surgery-Plastic-Otorhinolaryngology	$92,239
Surgery-Thoracic	$118,156
Surgery-Urological	$48,499
Surgery-Vascular	$118,156

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section or Rate Pages.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. Consideration will be given to insureds practicing in more than one rating territory and/or state.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

A. Professional Liability Coverage

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

B. Associated Coverages

The applicable minimum premium is determined by the type of coverage and is shown on the appropriate Rate Pages.

XII. PREMIUM PAYMENT PLAN

The Company may, at its discretion, offer the insured various premium payment options. Specific options may be referenced in the Rate Pages.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on the Rate Pages to the premium as shown on the Rate Pages.

D. Premium is fully earned and must be paid, in accordance with state statutes, promptly when due.

XVIII. GROUP PRACTICE

For the purpose of these rules, group practice shall be defined as a group of entities, physicians, and/or allied health care providers rendering patient care who:

A. Number 2 or more;

B. Are organized as a legal entity;

C. Share common facilities (including multiple locations) and support personnel.

XIX. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Scheduled Rating is not to be used in conjunction with Loss Rating.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are organized as a legal entity;

2. Maintain common facilities (including multiple locations) and support personnel; and

3. Maintain medical/dental records of patients of the group as a historical record of patient care.

C. Any exceptions to these rules are contained in the Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$100,000 Per Claim
$300,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated under B1 or B2 on page 7.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any applicable modifications. However, for groups of 10 or more physicians, the Company may base the maximum premium on the sum of the shareholders' rated classifications.

3. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met. These limits of coverage are shared, unless otherwise specified by endorsement.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the Rate Pages.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on the Rate Pages.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

Physicians and non Physician Health Care Providers up to 30%

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $1250.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Criteria applicable to the Schedule Rating modifications will be determined by the type(s) of health care providers found in the Physician/Surgeon and Health Care Provider Section of the Rate Pages. Schedule Rating is not to be used in conjunction with Loss Rating.

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non physician health care providers.

B. Any exceptions to these rules are contained in the respective Rate Pages.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$100,000 Per Claim

$300,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non physician health care provider shown on the Rate Pages, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a classification code according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The classification codes will be contained on the Rate Pages.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified on the Rate Pages.

2. A Part Time Practitioner may include any practitioner in classes 1 through 3 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated in the Rate Pages.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on the Rate Pages. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to 7E on page 20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on the Rate Pages.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented on the Rate Pages.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs unless stated otherwise in the rule or on the Rate Pages.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated on the Rate Pages, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on the Rate Pages.

B. Self-Insured Retention Credits

1. Self-Insured Retentions

a. SIR'S shall be offered to qualified insureds, provided the account generates $250,000 or more of manual premium. The eligibility threshold shall be 5 physicians in a medical group. The actual experience of the account will be

analyzed and the appropriate credit determined. The items considered in the determination of the applicable credit are: the historical paid frequency; historical paid severity; historical incurred severity; the historical allocated loss adjustment expenses as a percent of indemnity; the processing; acquisition and other expenses associated with the account; the variability of results; the credibility of the experience; the selected deductible annual aggregate; and the loss elimination ratio from the lognormal distribution. The table of SIR's and credits is below:

Per Claim Self Insured Retention	Credit Range As a % of 1M/3M Premium
$100,000	8% - 15%
200,000	14% - 25%
250,000	16% - 28%
500,000	26% - 44%
1,000,000	31% - 55%

b. SIR's shall be funded at the discretion of the Company, including vehicles such as irrevocable Letters of Credit, Cash or equivalent, or escrow accounts.

c. The SIR's shall apply to the indemnity and allocated loss expense portion of each loss unless otherwise modified by statute.

d. SIR's can only be revised at policy renewal.

e. The SIR credits shall apply to the primary limit premium, net of other applicable credits, identified on the Rate Pages.

i. The credits are expressed as a function of the Per Claim limit of liability or per insured and aggregate SIR limit.

ii. The insured may be eligible for an aggregate limit in accordance with underwriting guidelines.

iii. The maximum premium credit is limited to 75% of the aggregate SIR limit.

C. Experience Rating

1. A group practice, consisting of a specified number of insureds, may receive a credit/debit based on the claim history. The claims history will be evaluated over a minimum period of five years and a maximum period of ten years. Criteria used to determine the application of such credits/debits shall include:

    a. Premiums paid

    b. Number of claims

    c. Paid losses

    d. Paid loss adjustment expenses

    e. Cause of such losses

    f. Nature of practice

2. Such credits/debits shall apply on a one year basis and will be subject to annual review. Refer to the Rate Pages for the minimum number of insureds requirement and the applicable percentage credit/debit.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS I

NON-SURGICAL SPECIALISTS TO INCLUDE:
ACUPUNCTURE, ADMINISTRATIVE MEDICINE, AEROSPACE MEDICINE, ALLERGY AND IMMUNOLOGY, BRONCHO-ESOPHOGOLY, COLONOSCOPY, DENTISTRY (GENERAL), DERMATOLOGY, DIABETES, DISCOGRAM, ENDOCRINOLOGY, FAMILY/GENERAL PRACTICE, FORENSIC MEDICINE, GASTROENTEROLOGY, GYNECOLOGY, HEMATOLOGY, HYPERBARIC MEDICINE, INFECTIOUS DISEASE, INTERNAL MEDICINE, LARYNGOLOGY, NEPHROLOGY, NUCLEAR MEDICINE, NUTRITION, OCCUPATIONAL MEDICINE, ONCOLOGY, OPHTHALMOLOGY, ORTHOPEDICS, OTORHINOLARYNGOLOGY, PAIN MANAGEMENT, PEDIATRICS, PHARMACOLOGY, PHYSIATRY, PHYSICAL MEDICINE & REHAB, PODIATRY, PREVENTATIVE MEDICINE, PSYCHIATRY, PUBLIC HEALTH, PULMONOLOGY, RHEUMATOLOGY, RHINOLOGY, AND UROLOGY.

CLASS II

NON-SURGICAL SPECIALISTS TO INCLUDE:
CARDIOLOGY, GERIATRICS, HOSPITALIST NON-INVASIVE, NEONATOLOGY, NEUROLOGY, PATHOLOGY, RADIOLOGY-READING X-RAYS.

MINOR SURGERY FOR SPECIALISTS TO INCLUDE:
DERMATOLOGY, ENDOCRINOLOGY, FAMILY/GENERAL PRACTICE, GASTROENTEROLOGY, GYNECOLOGY, HEMATOLOGY, INFECTIOUS DISEASE, INTERNAL MEDICINE, LASERS, NEOPLASTIC, NEPHROLOGY, NEUROLOGY, ONCOLOGY, OPHTHALMOLOGY, OTORHINOLARYNGOLOGY, PAIN MANAGEMENT, PATHOLOGY, PEDIATRICS, PULMONOLOGY, UROLOGY

CLASS III

NON-SURGICAL SPECIALISTS TO INCLUDE: ANESTHESIOLOGY, HOSPITALIST INVASIVE, INTENSIVE CARE MEDICINE , URGENT CARE.

MINOR SURGERY FOR SPECIALISTS TO INCLUDE:
CARDIOLOGY WITH ANGIOGRAPHY, CARDIOLOGY WITH CATHETERIZATION, GERIATRICS, ORTHOPEDICS, RADIATION ONCOLOGY, RADIOLOGY WITH CONTRAST MEDIUM, RADIOLOGY INVASIVE.

MAJOR SURGERY FOR SPECIALISTS TO INCLUDE:
COLON and RECTAL, ENDOCRINOLOGY, GASTROENTEROLOGY, LARYNGOLOGY, NEPHROLOGY, NEONATOLOGY, OPHTHALMOLOGY, ORAL SURGERY, OTOLOGY, OTORHINOLARYNGOLOGY NO PLASTIC, HEAD AND NECK SURGERY NO PLASTIC, PEDIATRICS, RHINOLOGY, UROLOGY.

CLASS IV

SPECIALISTS INCLUDING:
ATTENDING PHYSICIANS EMERGENCY MEDICINE NO SURGERY/MINOR SURGERY, FAMILY/GENERAL PRACTICE WITH MAJOR SURGERY & OB, INCL C-SECTIONS, HOSPITALIST INCL ER, MEDICAL DIRECTOR.

CLASS V

SURGICAL SPECIALISTS INCLUDING:
CARDIOVASCULAR, CARDIOTHORACIC, GENERAL SURGERY, GYNECOLOGY, HAND SURGERY, NEONATOLOGY, NEOPLASTIC/ ONCOLOGY, ORTHOPEDICS, NO SPINE.

CLASS VI

SURGICAL SPECIALISTS INCLUDING:

EMERGENCY MEDICINE MAJOR SURGERY, OTORHINOLARYNGOLOGY WITH PLASTIC, PLASTIC SURGERY, THORACIC SURGERY, TRAUMATIC SURGERY, VASCULAR SURGERY.

CLASS VII

SURGICAL SPECIALISTS INCLUDING:
OBSTETRICS and GYNECOLOGY, PERINATOLOGY, ORTHOPEDIC SURGERY WITH SPINE.

CLASS VIII

SURGICAL SPECIALISTS INCLUDING:

NEUROLOGICAL SURGERY.

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Class 1

Psychologist

Class 2

Certified Registered Nurse Anesthetist

Class 5

Certified Nurse Midwife – No complicated OB or surgery

B. Manual Rates

1. Territory Definitions

AREA 1 COUNTIES

Cook, Madison, St. Clair and Will

AREA 2 COUNTIES

Kane, McHenry

AREA 3 COUNTIES

Bond, Clinton, Franklin, Hamilton, Jefferson, Washington, Williamson, & Rest of State

AREA 4 COUNTIES

DuPage, Kankakee, Macon and Winnebabo

AREA 5 COUNTIES

Lake and Vermillion

AREA 6 COUNTIES

Champaign, Bureau, Cole, Dekalb, Effingham, Lasalle, Ogle, Randolph and Sangamon

AREA 7 COUNTIES

Jackson

A. Standard Claims Made Program Step Factors and Mature Rates

a. Step Factors:

First Year:	25%
Second Year:	50%
Third Year:	85%
Fourth Year (Mature):	100%

b. Mature Rates (Claims-made):

See Rate Pages.

3. Mature Rates for non Physician Health Care Providers are calculated as follows:

Class X equals 10% of the Class 1 rate.

Class Y equals 15% of the Class 1 rate.

Class Z equals 25% of the Class 1 rate.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 4 rate.

1. Increased Limit Factors:

Limit	All Classes
100/300	1.000
200/600	1.174
500/1.0	1.500
1M/3M	1.900

2. Extended Reporting Period Coverage Factors:

(i) The extended reporting coverage factor is 200%.

(ii) For First Year and Second Year Claims Made steps, it is applied to the annual undiscounted premium at the time of expiration.

(iii) For Third Year and all years of maturity, it is applied to the mature annual undiscounted premium.

3. Shared Limits Modification:

Up to 25%

4. Policy Writing Minimum Premium:

   Physicians & Surgeons - $1250.

5. Policy Writing Minimum Premium:

   Non-Physician Healthcare Providers - $500

6. Separate Limits for Non-Physician Healthcare Providers Modification:

   Up to 25%

7. Premium Modifications

For individual physicians and surgeons:

a. Part Time Physicians & Surgeons – 30%
b. Physicians in Training – based upon hours, up to 50%
c. Locum Tenens – no premium, subject to prior underwriting approval
d. New Physicians & Surgeons – 30% for the first two years of practice
e. Physician Teaching Specialists – based upon hours, up to 50%
f. Physicians Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval

For Individuals and Groups, subject to Underwriting:

a. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 25%

b. Self-Insured Retention Credits for groups, subject to Underwriting

c. Experience Rating for groups with at least premium of $100,000 and 5 physicians, subject to Underwriting
d. Slot Rating for groups, subject to Underwriting
e. Premium Payment Plan - The Company may, subject to applicable guidelines, offer the insured various premium payment options. The premium payment plan requires a minimum of 25% of the total premium to be paid on or before the inception/renewal date of the policy. The balance of the premium will be payable in periodic installments. Other fees may apply.